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CLINICAL TRAINING FOR THE PASTORAL MINISTRY: PURPOSES AND METHODS

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Introduction

In its beginnings, clinical pastoral training was probably more "clinical" than "pastoral." This was both inevitable and desirable: Inevitable, because pastoral theology had to be rescued from the too-theoretical atmosphere of the seminary classroom and library and brought into touch with the life and death struggles of human souls—struggles which Anton Boisen knew from intense personal experience and the study of which he felt would bring fresh understanding and vitality to the cure of souls. Desirable, because a swing of the pendulum is usually necessary to correct faults in human thought and practice. The pendulum has swung; and clinical training is now gaining a proper awareness of and dedication to its task of preparing men for the practice of the pastoral ministry. This awareness, too, was inescapable, for supervisors of clinical training could scarcely evade for long the obvious fact that they were training men for the pastorate. Increasingly, clinical training has accepted and embraced this primary purpose.

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What follows is, frankly, as one reader of the paper put it, "a description and apologia for the writer's own program." Except for six years spent in the parish ministry (1948-1954), I have supervised at least one quarter of clinical training every year since 1940 when I inaugurated this program at Bellevue Hospital in New York City. This paper is largely the story of how this training has been given and why it was given so. Having supervised most recently in a correctional institution, it is flavored quite strongly by this experience.

I. Purposes of Clinical Pastoral Training

Clinical training for the pastoral ministry has three essential purposes: (1) spiritual health; (2) intellectual insight; (3) pastoral skill. In my opinion, this is the order of their importance.

Spiritual health must be paramount in any valid program for the training of pastors. What the minister *is,* is more important than what he *knows,* or what he *does.* He cannot really *know* or *do* anything rightly unless he himself *is* right. St. Paul put this whole matter most clearly when he wrote to the Corinthians:

> If I speak in the tongues of men and of angels, but have not love, I am a noisy gong or a clanging cymbal. And if I have prophetic powers, and understand all mysteries and all knowledge, and if I have all faith, so as to remove mountains, but have not love, I am nothing. If I give away all I have, and if I deliver my body to be burned, but have not love, I gain nothing.

Paul was speaking in general of the Christian life. What he said is even more true of the work of the pastor. Christianity is basically incarnational religion. It believes that the love of God is best revealed to men in human form; therefore, "the Word became flesh and dwelt among us." But Christianity is still incarnational, and God's love is still best revealed in human form through human lives. For this reason, when Christ was taken from his disciples, the Comforter was sent. The Holy Spirit came into the world with new power to continue the work begun in Christ. The incarnation is continued through the work of God's love still revealed to men today in Christ and carried out by the Holy Spirit in the transformation of human life—the Word becoming flesh in the lives of true believers—and in an especially important and useful way in the lives of those called to be pastors and evangels of the Gospel of Love.

A simple little story makes this point clear. It is about a little girl, being put to bed by her mother. As the mother was leaving the room and about to put out the light, the girl said, "Oh, Mommy, don't leave me! I'm so afraid alone in the dark!" The mother tried to calm her with the assurance, "But you don't have to be afraid. God is always with you." To which the little one replied, "Yes, Mommy, but I want someone with a skin face." Is not this the meaning of the Incarnation: that God sent His

Son into the world that we might have Someone with a "skin face" to show us the height and length and breadth and depth of His love? And is not a corollary of the Incarnation this: that the Church, as the body of Christ, is created by God to continue that revelation, and to continue it in a special way through its ministers who are given by God a special responsibility for the manifestation of His love?

Man, being made in God's image, possesses love as a part of his being. This essential quality may be thwarted or it may be perverted—as a stream may be dammed up or corrupted—and the purpose of the Church and the ministry and of theological training is to remove the obstacles and impurities so that pure love may flow freely from the lives of men and women. In pastors, intellectual insight and counseling skill are comparable to the channels in which a stream flows. Channels may be good or bad, and may thereby help or hinder the ultimate usefulness of the stream; but of first importance is the quality and quantity of the stream itself.

I remember meeting a young student from India walking across a seminary campus one cold, but bright, winter day some years back. His comment to me that day has stuck in my mind. "The sun today reminds me of this school. Lots of light, but not much heat." In terms of our other figure of speech, this could be translated, "A good channel, but not much of a stream."

A former student of mine has written this about his seminary days: "The life of the school was firmly grounded in hard work and sustained by the chapel services. The life of study and the life of prayer did not come easily. With firmness and patience, the faculty blended high standards and love to create a Christian community which we gradually came to understand. It took three years and more for us to realize that *the love of God is learned, not through books, but through being loved.*" I like to think this student's three months in clinical training helped to clarify this insight.

In any case, I hope my meaning is clear when I say that *spiritual maturity* is of first importance, and that what a student learns *to know* and *to do* is good only when what he *is,* is also good. Alfred Adler puts this same concept in these words to therapists: "The technique of treatment must be in yourself." The most important fact about any counselor is his own spiritual or emotional health. It is good first to "take the log out of your own eye; and then you will see clearly to take the speck out of your brother's eye." This point is labored at the beginning of this paper because it is determinative of most of our procedures in clinical training.

To say that spiritual health is the primary requisite for pastors and the greatest concern of clinical training as it deals with students is not to say that this is the most obvious goal of training or that we spend the

greatest amount of time in the training program discussing the students' emotional health or providing therapy for them. More frequently, spiritual therapy or growth comes about more as a by-product of the training program in the pursuit of its other objectives. The supervisor need not make therapy an obvious goal at all; but he always recognizes that the emotional and spiritual growth of the student may be the most important achievement of the program; and he is constantly alert to such possibilities and encourages such growth.

A second objective, and the one upon which the training program is usually focused, is intellectual insight, particularly in the area of understanding what human beings are like. Some of the basic questions considered during clinical training are: What are the major elements of human personality? What makes for emotional and spiritual health or normality? What are the causes of personality breakdown? How is psychic health related to physical health and how does psychic conflict relate to physical disease? What are the inner motives of antisocial behavior? It is inevitable in considering such questions that we relate what is learned to such basic Christian doctrines as God, Man, Sin, Salvation, the Church, Forgiveness, and Eternal Life. The students' use of theological concepts should be infinitely enriched as he learns to understand their use and meaning in human experience. This kind of understanding can put flesh on dead bones. The student in clinical training, as Dr. Boisen so often reiterates, is studying these Christian experiences in "the living documents."

After understanding people, our next objective is to help them. The student group, with the supervisor's help, seeks to use this understanding in ways that will contribute to the spiritual health of the souls committed to their care—both in the institution during the training period and in their entire future ministry. They should learn much of how religion, the Church, and pastors can function constructively in the lives of people—how they can aid in both the prevention and cure of physical, mental, moral, and spiritual illness.

II. How Are These Pastoral Objectives Achieved in Individual Relationships with Students?

It is my custom to see each student in the training group for an individual conference of at least one hour at least once each week. It is desirable that such conferences be longer and more frequent, but that is not always possible.

In my experience—and, I believe, in the experience of supervisors generally—it is in these conferences that the need to choose between a teaching and a counseling role in relation to students becomes most acute. My own practice is to give the student some freedom of choice in this matter. I indicate at the beginning of the training period that students use these periods in different ways; that, no matter what our

focus, there is bound to be both teaching and therapy in these relationships.

Most of these conferences begin with the focus on recorded interviews and student-inmate relationships. None of them remain narrowly focused on the inmate or what the student said or did in the relationship. Inevitably the question "Why?" in regard to the student arises. Why does he have such difficulty recording his interviews? Why does he relate so aggressively to this inmate? Why does he readily run errands at inmates' requests? Why does he want to reassure everyone who is disturbed? Why is he so eager to use religious panaceas, i.e., prayer, confession, and forgiveness? Why does he over-identify with this inmate? Obviously, all these questions relate to what the student *is,* and how he is expressing what he *is.*

With some students, raising these questions leads to change of focus from the inmate and the student-inmate relationship to the student and all his relationships. Sometimes the student's relationships with other students, with the supervisor, with other staff people present considerable difficulty and the kind of pressure which forces a focus of concern on these areas. Sometimes the discussion of case material in the training program is so disturbing to a student or is so conducive to introspection in the student that this also leads to a focus on the student himself in the supervisor's individual conferences with him.

In the last three summers I have supervised nine students. With three of them the focus remained on inmates and student-inmate relationships; with four the focus was on the students' own problems and their whole range of relationships; with two there was a mixture of concern, not predominantly one or the other. I would have difficulty in saying which students did best work in the training program or which made the most progress—except that the two students who made no clear choice to use the weekly conferences one way or the other probably benefited least from these conferences. This was probably due to faulty supervision and each of these students should have been given some help in making such a choice. I suspect a weakness in the supervisor-student relationship which should have been subjected to scrutiny in the conference periods.

A great deal of help can be given the student in developing his skill as a counselor through the careful analysis of his recorded interviews. This I shall discuss more thoroughly later in considering the student's work as a chaplain. But let us point out here that pastoral skill is more a matter of what the pastor is and knows than it is what he does. "The technique of therapy must be in yourself." It has been said, concerning the treatment of schizophrenics, that the therapist may make mistakes of the head, but not of the heart. Having the heart right is of first importance in any therapeutic relationship. Generally, good counselors say and do the right things because they feel and understand rightly about the counselee. The supervisor-student analysis of recorded interviews should therefore be considered more as research concerning the counseling rela-

tionship than as teaching. Didactic advice from the supervisor, such as "Don't rush reassurance" or "Avoid giving advice," is not nearly so helpful as asking "Why?"—as suggested above.

III. How Are These Pastoral Objectives Achieved in the Training Group Experience?

Much of what a student gains from clinical training comes from his relationships with the entire training group: supervisor and other students. Some of these group experiences are formal and planned; others are informal and spontaneous. Planned seminars are held with some frequency during the training program. An optimum schedule would call for one or two seminars each day at least five days each week.

The major goal of these seminars, as I use them, is teaching, not therapy. There should be a basic body of knowledge, insight, or understanding which the training program gives to students. It is in these seminars that I seek to help students gain this insight. To the best of my knowledge, no serious attempt has been made to formalize or to put on paper the intellectual content of the training program. Because the method of clinical training is predominantly non-directive and a kind of teaching through research and the use of clinical material, there has been no clamor and, indeed, no need for a textbook which would state this content. While there might be some value in such a volume, it might also cause some harm, particularly if it gave the impression that this was the whole of clinical training or that reading such material could in any sense be a substitute for clinical training. In my recent training programs I have tried to transmit through clinical methods some intellectual insight which should prove of real value to pastors in the following areas:

1. *The institution and how it functions.* At the beginning of the training program, seminars are scheduled with various staff people, so that the students are thoroughly introduced to and acquainted with the setting in which they will work. During the course of the summer a sense of being "at home" in this type of institution should be thorough and lasting—and an important contribution to the future ministry of these students in similar institutions.

2. *The nature of man.* In this area, as suggested above, we lean rather heavily upon both psychiatry and theology. The research of Freud and those who worked with him and followed him in this field in the past 65 years has tremendously increased our detailed knowledge of the mental and spiritual life of man. And they have also immeasurably enriched our understanding and appreciation of the body of dogma and custom of the Christian Church as these things relate to the nature of man and his needs. I have always sought out a learned psychiatrist, one sensitive to the spiritual needs of people and appreciative of the Church's potential contribution to our people and our communities, and have used these men in regular seminars with students. Sometimes they have presented theoretical

material as a framework for understanding people and their behavior; sometimes they have dealt with case material exclusively. In my present setting I have the great good fortune of having the cooperation of a sympathetic and well-trained practicing psychoanalyst, Dr. James T. Thickstun of La Jolla, California, who has given our training program one full evening each week throughout the summer. These evening seminars have been largely unstructured. Although we begin each evening with a plan to consider either some basic aspect of human nature or some specific case material, questions and discussion flow freely and spontaneously, and insight comes through a group experience shared by all.

3. *To become acquainted with other professional people dealing with individuals in crisis, and to understand their approach to the problems of human beings is another important goal of training.* The clergyman can learn much from the insights and methods of the psychiatrist, the psychologist, and the social workers; and he should acquire at the beginning of his ministry a capacity to work cooperatively with these and other professional people—medical specialists, nurses, administrators, probation officers, group workers, and others. To know something about the professional language of these people alone is of great value. To achieve these ends, seminars are planned with them, in which we try to understand their role in the community and/or the institution and the insights and methods used to fulfill that role.

4. *Community organization for social welfare.* In order that students might reach some understanding of how a community organizes to combat its social problems, we schedule seminars with professional people so that they will not only represent their professions, but will also be representative of the social agencies of the community. At least one seminar each quarter is scheduled with the director of the Community Welfare Council (coordinating agency) or one of his top assistants. He discusses with the students some of the problems of getting a community organized to minister effectively to the needs of its people.

5. *The development of pastoral skills.* Understanding people and their communities is not enough. The pastor should also have some "know-how." While this is not the primary objective of clinical training, certainly much time is given in seminars to a discussion of practical aspects of the minister's task. Particularly, this is true in regard to the pastor's work as a counselor. At the beginning of the summer, several seminars are used to suggest the most important principles to follow and to point out the most common errors in counseling. Problems in counseling also present themselves frequently in seminars of an unstructured nature, in which students present any ideas or material they wish to discuss. These will often include questions about the whole range of the minister's task: preaching, worship, religious education, youth work, adult groups. At the end of the summer, we schedule several seminars which are devoted to problems in this area.

6. *Philosophy and theology.* Clinical training has sometimes been accused of failing to integrate its teaching with that of the entire seminary curriculum, particularly in the field of theology. In my experience this is a false accusation. I have never known a training program in which a serious effort was not made to help the entire training group "think through" the theological implications of the training experience and to integrate that experience with the seminary training and the ecclesiastical background of the student. Many hours are given to this task by the student group whenever such questions are raised in seminars throughout the summer and in seminars scheduled for that specific purpose near the end of the summer.

To indicate the number and nature of the scheduled seminars of a training program, the primary purpose of which is teaching, I have made the following analysis of our program last summer. There was a total of 61 seminars for supervisor and students; of these, two were scheduled for the presentation of strictly didactic materials; twenty were based on case material previously prepared; five were for discussion of clinical material from the students' own experience during the summer; four were concerned with problems raised by students involving the implications of their summer's experience for theology, the ministry and the Church; and eight were completely unstructured as far as content was concerned. There were eight seminars with Dr. Thickstun, of which two dealt with psychological theory and six with case material. There were fourteen seminars with other professional people: two with psychiatrists, two with clinical psychologists, two with social workers, two with a correctional counselor, six with institutional or agency administrators, and one with a public relations counselor. These represented eleven community agencies.

While the group experience of students in training is not conceived of primarily as a means of therapy, I have always been aware, as a supervisor of clinical training, of its great therapeutic potentiality and of the therapeutic results of the group experience. Many of the ingredients of a strictly therapeutic group are present: the size is small (six is a maximum group of students for one supervisor); the supervisor's role is non-dogmatic and non-directive; teaching is accomplished through research and discussion; there is a focus of concern on feelings; contacts within the group are prolonged and intense; students are stimulated by the nature of the clinical material as well as by the quality of the group to a clearer and, sometimes, more intense awareness of their own feelings and problems. Sometimes personal feelings in the group are expressed and discussed openly in group sessions. More frequently, in my experience, they are discussed in individual conferences. But even then they must be worked out in the relationship in which they are felt. I have known students whose most significant growth during the quarter has come about as a result of analysis and understanding of his relationships in the group and the development of new skills in handling the feelings involved in these relationships. Sometimes such insight comes in a

flash—as with the student who suddenly learned that he could express his resentment toward others in the group who had been taking advantage of his masochistically repressed hostility; and who learned that he thereby became less resentful, partly because his hostile feelings were expressed and partly because, being less masochistic, he was less picked on. Although the problem was discussed only in individual conferences, it rose out of the group relationship and could be worked through only in the group relationship. This kind of therapeutic experience is duplicated every quarter, although usually in less dramatic fashion.

IV. How Are These Pastoral Objectives Achieved in the Chaplaincy Program?

During their quarter of training, students serve the institution as Chaplain-Internes. In this capacity they engage in all the activities of the Chaplain. In our training center, the San Diego County Honor Camps, students conduct worship services; they preach in these services; they organize and conduct discussion groups (some concerned primarily with religious subjects, others not); they interview inmates while they are in the Reception Unit and prepare reports on their observations of men during their diagnostic period (first three weeks in the camps); at the end of this three-week period they participate in the classification committee's discussions of the men they have come to know; they counsel intensively with a few inmates (two or three interviews a week with each inmate for at least three weeks, sometimes throughout the quarter); and they are always available to and frequently used by inmates for counseling with personal problems (these are usually situational problems, but they are sometimes inner problems, and the request for help can develop into an intensive counseling relationship). In all these activities students are practicing their pastoral function and are doing so under supervision. Opportunities are made to consider problems arising in these activities both in group seminars and in individual conferences.

The greater portion of a student's time in chaplaincy functions is given to his intensive counseling relationships. He is asked to make a careful record of these relationships, recording all his interviews with these inmates as nearly verbatim as possible. Considerable time in the Supervisor's Weekly Individual Conference with students is spent in a critical analysis and evaluation of these interview reports, with two primary concerns:

1. *Understanding the counselee and the counseling relationship.* At the end of each written interview report the student writes a brief paragraph interpreting what the inmate said or did. The purpose of this is to develop the capacity to see beneath the surface of what goes on in a counseling interview. Similarly, the student writes a paragraph interpreting the counseling relationship, so that he may learn to sense the importance of a counselee's feelings toward the counselor, and vice versa.

For example, in an initial interview an inmate makes the statement, "I guess I'm an atheist." Shortly after he volunteers the information that his father is an active lay missionary. One should immediately raise questions about the meaning of these two observations in relation to one another. Is his atheism a means of expressing his feelings toward his father? Is the inmate conscious of this connection? Questions should also be raised about the meaning of these observations for the counseling relationship. Since the student is a religious worker, will the inmate put him in a role similar to his father's? Is his open suggestion of atheism an indication that he has in fact already done so? Does it imply hostility—conscious or unconscious—toward both worker and father? From this kind of recording and analysis comes an ever-increasing understanding of the nature and meaning of the inner life and of the deeper meanings of the pastoral relationship.

2. *Improvement of pastoral skill.* To see how quickly easy reassurance stops the free expression of feeling (particularly anxiety) is one of the best ways to avoid making the same mistake in the future. To encounter resistance or strong hostility as a result of premature interpretation to a client is probably the best way to learn the dangers of interpretation. At the end of each recorded interview the student prepares a paragraph evaluating his responses in the interview. This kind of recording and evaluating leads the student to a healthy criticism of his dealings with the sensitive spiritual life of those he seeks to help, and makes it possible to plan future interviews with a thoughtful and prayerful concern for his counselees' spiritual health and growth.

In the correctional setting, the student frequently develops considerable anxiety as he approaches his role as Chaplain-Interne, and in a somewhat different way than in other types of centers. The obviously unique element in this type of institution is the "acting out" behavior of our clients, particularly the overt expression of their hostilities. The atmosphere of the institution is heavy laden with aggression. Not only are inmates given to overt expression of their hostilities, but staff, too, are generally more overtly aggressive than staff in other institutions. Partly because of the reality of this hostility in inmates and staff, and also because of their own masochistic needs, students frequently develop considerable fear as they approach what seems to them a threatening situation. It is quite probable that theological students have more poorly developed patterns for handling aggression than have most people in our culture.

Learning to understand his anxieties in this setting and to accept his pastoral role with inmates and staff leads to tremendous personal growth. In my experience as a supervisor, watching and aiding students as they worked with this problem of aggression in the correctional institution has been one of the most rewarding aspects of my ministry. Learning to deal constructively with hostility in others and in one's self is one of the major tasks of any life, but it is particularly important in the life of the pastor.

This particular kind of learning seems to take place more readily in the correctional setting than in others. The student who helps an inmate transform blindly antisocial hostility into constructive and socially useful purpose acquires some important insight into a basic human problem, works out some aspects of this problem in himself, and receives deep satisfaction from the job he has done. This same kind of understanding and growth and satisfaction develops out of all the student's relationships—with groups as well as with individuals, with staff as well as with inmates—in the correctional setting.

Not that hostility is the only aspect of the human problem with which students in the correctional field deal. Our clients have equally serious defects and disturbances in their erotic adjustments. The typical inmate has a thoroughly debased view of the sexual impulse and has had a rather well-rounded and lurid sexual history; but he also has had a conspicuous lack of any satisfactory experience of love, and sometimes he expresses highly idealized concepts of womanhood and of marriage which are thoroughly incompatible with his sexual ideas and feelings. Obviously, this is also an important problem for the whole human family, and one which the pastor had better understand and learn to deal with in others and in himself. One of my students last summer counseled with an inmate who, like most of our men, indicated no feeling of sexual inadequacy and considerable confidence that his love-life was satisfactory. In our supervisor-student conferences, we shared our questions about this professed adequacy in the sexual realm and wondered if the inmate was at all aware of the really unsatisfactory quality of this aspect of his life. The student's record of the last interview with this man (conducted after the inmate's discharge), contains this: "While driving, Jim began to take notice of young females and frankly stated that his sexual appetite was high. He pointed at one girl and said he would like to give her a tongue bath. A few minutes later he stated that he thought his sex experiences with girls had not been based on love, real love, and that he felt a need to love a woman and indicated that he thought this was an essential part of his life." In evaluating this comment, we felt that it definitely indicated some growth in the counselee, expressing, as it did, a feeling of inadequacy which he had not expressed, and a striving for health he had not shown previously. We also felt that this growth was a result of the counseling relationship, in which the inmate for the first time, maybe, felt comfortable enough in an important relationship to look at himself honestly and to face up to his anxieties and inadequacies.

As in dealing with hostility and its expression in his counselees, the student makes personal growth in his capacity to understand and handle his own aggressive impulses; so, too, does he grow in the understanding and direction of his erotic drives. This, too, is a basic ingredient of human personality, and dealing with it constructively is a problem universally presented to all persons. And, again, it is particularly important

for the pastor to have a wide understanding and a large measure of personal adequacy if he is to fulfill his pastoral role effectively. Such understanding and personal growth do result from clinical training.

We could obviously elaborate indefinitely concerning the kinds of problems the student deals with in his work with inmates. The illustrations we have already used indicate the two great ideas of human emotional difficulty: love and hate. Jesus himself pointed to these as the two great moral and spiritual problems of human life: "It was said to the men of old, 'You shall not kill. . . .' But I say to you that every one who is angry with his brother shall be liable to judgment." And "It was said, 'You shall not commit adultery.' But I say to you that every one who looks at a woman lustfully has already committed adultery with her in his heart." In the clinical setting of the correctional institution these basic and timeless pastoral problems are presented with dramatic force and clarity. To help the student and, through him, to help his present and future pastoral charges reach some approximation of Jesus' ideal is the goal of clinical pastoral training. The task is not easy. But it is important. I wonder if there is anything more important than this in the training of pastors; or if there is any training which can accomplish this as effectively as clinical pastoral training.

THE OCCURRENCE OF MENTAL ILLNESS IN THE MINISTRY: FAMILY ORIGINS

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As we listen to patients talk, during the process of psychotherapy, we gain an intimate view of the current life of the individual as well as a retrospective glimpse into his origins. Prejudiced and biased as this glimpse often is, it nevertheless has value when compared with other similar observations.

Perhaps we may make an analogy to a bit of tissue examined under a microscope. The first thing noticed may be that it is magnified in size. Then the intricate, complex structure of the specimen is observed. Although staining techniques may have added some artifacts and produced some distortions, it is possible to recognize different tissues. Within certain limits, a pathologist can make certain assumptions and draw conclusions about the functioning of the organ and the individual whose tissue is being examined. So, in a sense, it is with the patient in the psychiatrist's office, where, over a period of time, the person may be studied in detail. We see the patient's life, albeit magnified and distorted by his viewpoint. We marvel at the intricate and complex structure of personality. If we compare one patient with another, we find certain similarities and certain differences. With experience it is even possible to recognize that which we call normal and separate it from the pathological. Further, within limits, certain conclusions and assumptions may be reached concerning the patient and his life, even as the pathologist does when examining a bit of tissue. We must be well aware of the limitations of method and not carry the analogy too far, but the method of reconstructing life history from psychotherapeutic data has value when these data are compared to similar data from similar sources.

We know that environmental factors affect the developing structure of personality, although authorities often disagree regarding the relative importance of these factors. During infancy and childhood everyone is dependent upon others for his existence. In the normal course of events, personal needs, wishes, and desires are satisfied or frustrated within the family situation. With maturation and development, the child becomes an

adult who strives for independence and actively seeks satisfaction of his needs. The manner in which these needs will be satisfied will be influenced by the family, its mores and customs, as well as by the general culture. Acceptance by one's fellow men, for example, is a common social need. In one family group such acceptance will be gained by intellectual prowess, in another by mechanical aptitude, and in a third by thievery. The need is the same, the manner of satisfying the need varies. Family values affecting individual development are determined in part by the cultural values of the society in which the family lives. In order to understand the psychopathology occurring in ministers, we must know something about their background.

In our society it appears that there is in progress a transition from a paternal to a maternal organization. The sociological and economic effects of this transition must be left for others to discuss. Here we can report only the effect it seems to have on the people we are studying. In the families of those working in the field of religion, the mother seems to be the major dominating influence. The feminine role, it seems, is becoming more complex and more ambiguous than it was even fifty years ago. Increased demands made upon the women for more active participation in society, plus the changing status of the male, affect the relationship of man to wife as well as that of parent to child. There is no clearly delineated pattern of conformity and, while old standards and mores are still in effect, they no longer have the same force as they once had.

The mother, as has been said, seems to be the major dominating influence in the home, not only on the child during his infancy, but throughout his life. This influence, in our cases, was not limited to the home, but extended to other situations as well. In general, the concern the mother felt toward her child was not always altruistic, but reflected her preoccupation with herself and her needs. Superficial examination might give the impression that the mothers of the patients were kindly, loving people concerned about the welfare of their children. During initial interviews the mother was often described as "a good Christian woman" or "a hard worker devoted to her family and church." It was only later in therapy that another character of the mother emerged. This also was often distorted and it was only relatively late in treatment that mother was seen in her true perspective with her faults and other attributes. It is this latter characterization that we shall attempt to describe.

Toward her husband the mother often feels in conflict, a feeling which generally is concealed from those outside the family. The nature of this conflict is complex. Usually she feels inferior and unable to accept certain passive-dependent needs relative to her femininity. Apparently she must then protest by asserting her superiority, denying her passive-dependent wishes and behaving in an aggressive, often dominating fashion toward other members of the family. Frequently she has unconsciously chosen as a mate one whom she can feel superior to and dominate. This

choice of mate, however, may cause conflict since it is often contrary to her unconscious dependent wishes and needs. If, perchance, her husband should rebel against this domination, either actively or passively, she tends to feel threatened and may use various unconscious devises to maintain her ascendancy. One of the most frequent of such devices is the use of sexuality, which is given or withheld in order to maintain a sense of superiority. In other instances sex may be submitted to as a necessary duty without any pleasure or satisfaction. Only rarely among the families of those studied in which there was pathology does it appear that the sexual relations between husband and wife are satisfactory. Overt demonstrations of love, such as kissing, were rarely expressed in front of the children and were usually accompanied by feelings of embarrassment. One wife would never permit any demonstration of love before the children and would permit intercourse only once a month and then only after entreaty by her husband, who would apologize for his demands.

We find that the mother's attitude toward her children is equally ambivalent, not to say rejecting. In many instances the children become narcissistic love objects and she reacts to them as if they were herself. Often they are used in an attempt to satisfy her own frustrated, unacceptable wishes or to obtain what she desired but could not have. Her dependency, as an example, can be denied to herself but expressed through her children by keeping them within the home and not allowing them to grow up and leave the home. Because her own sexual needs are so often frustrated, her sons tend to become unconscious sexual objects. She may be unconsciously sexually seductive, but at the same time rejecting any response. It is not uncommon for sons to sleep in the same room or same bed with the mother into high-school age and in several instances this practice was continued while the son was of college age. Dressing in front of the sons and access to the bathroom during bathing and toilet are other common expressions of this unconscious seductiveness which has its effect on the child.

With her daughters a somewhat different situation prevails. She unconsciously wants them to have the satisfying sexual experiences she denies to herself. But this must be repressed with the result that, while overtly she may be overly protective, not infrequently she condones promiscuity. One such mother used to berate her daughter for staying out late on dates yet questioned her avidly concerning her sexual escapades and permitted her to continue her behavior by not forbidding dating. More commonly, perhaps, the mother regards the daughter unconsciously as a competitor and tends to inhibit and stifle the daughter's natural desires toward womanhood. Actually the relations between the mother and her children are quite complicated and do not admit of generalities, but each must be specifically understood in individual cases. In any event, the mothers we are concerned with seemed to be mainly unsatisfied in the family group and tended to turn to substitutive sources of satisfaction.

Religious works or concerns seemed to be one common major source of substitutive satisfaction for these women. This is not to say, nor does it imply, that all religious work is of this nature nor that all women who have an interest in this work are neurotically seeking substitutive gratification. The fact remains, however, that with few exceptions these women, the mothers of the patients, were active in the church and had a rigid fundamentalistic conviction regarding their religious beliefs. This preoccupation with religious and church activities seemed to serve several social and psychological needs. The underlying motivations and satisfactions could not be determined in the course of this study. They would make a fascinating subject of investigation for some sociologist or psychologist and might clarify further the meaning and use of religion.

As previously mentioned, society seems to be undergoing a major transition. The fathers of the ministers studied also reflected the cultural changes, but in a somewhat different manner than did their wives. Superficially, most appeared to be the heads of their families, but this seems to be a nominal title only. Usually the father tends toward being passive and dependent in his relationship with his wife, the dependency being accompanied by a feeling of fear and guilt. In such cases alcoholism may be present as a symptom of the father's problem. Because of feelings of insecurity and inferiority, the father is often afraid to assert himself in relationships with his wife. In such situations two solutions appear to be common. First, the father tends to succumb to the situation, sacrifice his status, and accept a passive-dependent relationship. Secondly, the father may rebel, either actively or passively, and withdraw from the relationship. When the rebellion is active there seems to be a constant arguing and bickering between man and wife with a corresponding lessening of positive feelings in the relationship. With passive rebellion there is withdrawal from family participation, often with the father turning to his work in an attempt to find some satisfactions. It is interesting to note that in the group studied there was not a single case of divorce, although in several instances the parents separated for short periods of time. This may indicate that both parents receive some satisfactions in the relationship which compensate for the difficulties they experience.

Since his wife is generally felt as frustrating, the father also tends to use the children for substitutive expression. In this, also, he tends to meet with disappointment. Because of the nature of the family constellation, his sons tend to relate to the mother rather than to the father. He would like them to be what he isn't and wants them to be. With his daughters he feels uncomfortable and ill at ease. He has difficulty in relating with love because of his fear and guilt concerning the unconscious sexual feelings. In general, however, he tends to relate better to his daughters than to his sons. In a few situations, which were grossly pathological, this sexual interest in the daughter was acted out in the form of

incest. More often, it falls short of incest, but does involve various forms of sexual play from excessive kissing to fondling.

Religion, for the most part, does not seem to offer the father the outlets that it does his wife. In a relatively few instances, however, the father was the major factor in the religious life of the home and actively participated in church affairs. A surprisingly few fathers were ministers, but not enough information is available to make any general statements concerning them. It would appear that those fathers who do not use religion as an outlet have wives who have already pre-empted this role. We find most of the fathers turning to their work in their endeavor to find substitutive gratification. It is of interest to note that in these cases, while the father works hard, he very frequently fails to achieve the material success which might be warranted by his work. One individual, for example, has worked at two jobs for many years, yet always is in debt.

Most of the families studied had several children, with a range of from one to eleven. The average number of children was three. Usually only one child in the family decides to go into the ministry or other religious work, but as usual there are exceptions. Factors involved in the choice of religion as a profession will be discussed in later articles. The numerical rank of the child in relation to his brothers and sisters does not seem to be an important factor in the choice of religion as a profession. Relationships between the siblings seem to follow the same general pattern that it does in other family groups in our culture. Usually, if the child is the oldest, there tends to be resentment toward the next youngest child and acceptance of the others. If the child is in the middle, there seems to be envy of the older children accompanied by some resentment of the younger ones. The youngest child tends to envy the older brothers and sisters and, in this group of families, generally tends to feel inferior.

The sex of the child is, of course, important in relationships with parents, siblings, and others. Its import is not only biologically determined but culturally conditioned. In rural communities, for instance, male children are more desirable for economic reasons and the female tends to be or feel rejected. This seems to be less true of the city families. Generally, in our society, the male child is allowed more freedom than is the female child, and the females often tend to react to this with a sense of inferiority and envy. Competition with the opposite sex or members of the same sex is affected by the family attitudes, and this influences relationships with others. For example, a female seminary student who had several brothers had to prove her superiority by excelling intellectually. In classes she was argumentative and always had to demonstrate that she was as good or better than men. On dates she always chose a man whom she could dominate and toward whom she could feel superior.

With the group of ministers and religious workers studied there was a sense of universal rejection by the parents. This was especially pro-

nounced in regard to the parent of the same sex, and there was a tendency to identify with the parent of the opposite sex. This of course represents the Oedipus conflict, which in these people has a more or less pathological solution. Trauma of a psychological nature generally has been experienced prior to this developmental phase. The nature and effect of these experiences will be elaborated in later articles.

Interestingly enough, while the family groups showed evidence of much disharmony, the outward appearance often gave the opposite impression. During initial interviews, family life was frequently described by such statements as "We had a good Christian home." Too often such a description meant that the family went to church on Sunday and the children attended Sunday School, while within the home there was much turmoil and trouble. Another surprising finding was that in the families studied, as mentioned earlier, there were no instances of divorce. In fact, in only two families was there temporary separation between the parents. An incidental survey of 324 families of students in a local seminary revealed divorces in only 18 families. For reasons of guilt, shame, or pride families of ministers or religious workers in the group here studied kept their troubles to themselves. It is only under unusual circumstances that this bond of secrecy is broken. Since satisfactions are often minimal within the home, substitutes are sought elsewhere. Unfortunately, the needs which are frustrated cannot really be satisfied in this substitutive fashion. Consider the mother who is active in local church, civic, and social affairs, who is always willing to participate in a luncheon or discussion group, thus spending hours every day away from home. She may be regarded as an active, intelligent, social-minded individual. The fact that she leaves her children, aged two and four, at home alone to fend for themselves is a measure of her rejection.

Another characteristic of these families which is worth mentioning is the attitude toward education. The family will often work as a unit to have one or more members graduate from college. Usually it is the male children who are thus encouraged to go to school and sacrifices are frequently made by the parents in order to provide such education. With the female children, educational achievement is used as a means of competition with brothers as well as an attempt to gain acceptance and love from the parents. Collectively the family unit shares a certain amount of prestige from the fact that one of its members is attending college. Emphasis upon "good" grades is marked and the family gains status because of such grades. Its effect upon the future minister or religious worker is the garnering of knowledge for display rather than for use. It is reflected in the not uncommon complaint of seminary faculties that the students are adept at memorizing but are unable or afraid to think.

With few exceptions, these family groups tend to be in the middle or lower economic level, generally in the lower. While they seem to be

actively striving for economic security, they seldom attain a state of economic independence. Reasons for the inability to achieve some economic security seem to be rather complex and to involve the inter-reaction of neurotic needs within the family. As mentioned previously, the father tends to retreat to work as an outlet for frustrated needs. While he uses his work to obtain satisfactions, yet, because of inner conflict, these very satisfactions must also be frustrated. In this he is often aided and abetted by his wife, who frequently undermines his endeavors. The father of one of the patients studied, for example, was a farmer who worked long and hard at his labors. He was admired and respected by his neighbors and friends and hated by his wife. When he was elected an officer in the local Grange her comment was, "So you weren't good enough for an important job." Another wife commented, when her son announced his decision to enter the ministry, "Good, then you'll be something beside a common dirt farmer." The hostilities are apparent and effective in determining attitudes within the family group.

As mentioned earlier, American culture is in the midst of a transitional period. General attitudes within the families of the people studied often reflect the changing times. Familial lineal ties are tending to be dissolved and these families tend to resent intrusion by other blood relatives into their affairs. This change is perhaps more pronounced among city families than among rural ones. With the growing up of the children, the old family unit tends to dissolve. This resolution, which is generally desired by the children, is objected to by the adults. They feel their security vanishing; hence, the children break with the home through the medium of hostility and rebellion, often accompanied by feelings of guilt associated with dependent longings. In other instances, the dependent needs are stronger than the rebellious hostility and the children maintain a dependent relationship. The problem of caring for aged parents is met in part by keeping them in the home, but most of the parents of the people studied were not of retirement age. There may be some evidence to show that they will resent assuming responsibility for their care when the need arises.

Concerning the religious beliefs held by these family groups, the tendency seems to be toward a fundamentalistic faith. Families and individuals from a rural environment seem to favor such concepts more than do their urban counterparts. As a result, when these individuals who have such a fundamentalistic background are exposed to a liberal theology they often have real problems of adjustment. Of 26 individuals suffering from severe neurosis or psychosis requiring intensive psychotherapy, 17 were from rural areas and fundamentalistic in their religious beliefs. Further, these individuals tended to use their religious beliefs in a manner which might be judged unrealistic, poorly adaptive, or defensive. In other words, their religious beliefs were an integral part of their neurosis or psychosis.

It seems apparent that family environment affects the development of the personality and is a factor influencing the choice of religious work as a profession. The details of such influence are not all readily apparent from the material presented. Systematic study of the family backgrounds of ministers and other religious workers would seem to be a valuable area of research for a sociologist so inclined. We are now ready, following the introduction and family survey, to consider mental illness more specifically as it is found in those who work in the field of religion.

PARISH CLERGYMEN'S ROLE IMAGES AS PASTORAL COUNSELORS

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If the clergy is to be studied in a way which provides for systematic comparison to the secular professional, the problem must be divided into role structure and role content. This paper will deal only with role structure, or the latent effects of clergy-parishioner or professional-client relationships upon the extensity and individualization of relationships in the larger society. In this respect the important roles of the clergy are: (1) *congregational leader,* in which he creates a relatively small and permanent fellowship group which mediates between the individual and the mass society; (2) *symbolizer* (ritualist, preacher, teacher), in which he creates a reference group, imposing ideas upon a mass of people; (3) *pastoral counselor,* in which he deals with the unique needs of individuals, making possible a large-scale and individualistic society (on another level, *ethical leadership in the community* performs this latent function also). (4) A fourth set of roles, those of *parish administrator, career man,* and *leader of the religious community* in competition or conflict with others in the secular community, will not be considered here.

It is the role of the pastoral counselor which is structurally most similar to the role of the secular professional. Now the question arises as to the extent to which the parish clergyman can be modeled after the secular professional, as would be implied in the increasing emphasis upon pastoral counseling today, since his congregational leadership and symbolizing requirements may limit his ability to meet the unique needs of socially mobile individuals. There are at least three possible consequences if the parish clergyman takes counseling as his central role: (1) Strains may develop between the counseling and the other roles. (2) Strains may be prevented because the roles not institutionalized for the secular professional become means for pastoral counseling, or vice versa. (3) The movement toward pastoral counseling may be an adaptation to the needs of a more individualized and mobile society.

In order to study what happens to the counseling activities of the clergyman when different roles are emphasized as central, intensive interviews were made with 22 clergymen: Conservative Jews, Roman Catholics, Episcopalians, Southern Baptists, and Congregationalists. Representatives of each type of faith were selected in a medium-sized city in the Southeast

and in a large metropolitan area in the Northeast. Attempts were made to obtain parishes of each faith in high-, middle-, and low-income areas. The structure rather than the content of the role was emphasized so that both formal and informal counseling, including requests for charity handouts, were studied.

The Central Role

Although the parish clergyman performs a multiplicity of roles, he may think of one as his central role, the one most important for his ministry in his particular church. There was a difference, however, between what the clergyman *said* was his central role and the role he actually *talked most about* in response to the questions, "What kinds of work did you do as a clergyman in the last week?" "Was this week typical?" The answers were analyzed into Bales-type "unit acts," each elaboration of a basic idea being counted as a unit. Thus if a clergyman said, "(I preach)," this would be one unit. If he said, "(I preach) (sermons) (twice Sundays) (to my people)," this would be four units.

When these implicit roles were taken into consideration along with the explicit ones, the distribution of central roles, along with the denominations represented in each, became: 9 pastoral counselors (1 Conservative Jew, 4 Episcopalians, 4 Baptists), 1 non-counseling visitor (Congregationalist), 6 ritualists (1 Conservative Jew, 4 Roman Catholics, 1 Episcopalian), 3 preachers (Baptists), 2 teachers (1 Conservative Jew, 1 Baptist), and 1 community worker (Congregationalist). Thus there were by this revision 9 counselors and 13 non-counselors.

It can be seen that the central roles were not quite coterminous with denomination but either included several denominations in the same role type or had the same denomination distributed over several role types. However, all the Catholics were ritualists and all the preachers were Baptists.

Congregational leadership, although explicitly mentioned by no one, implicitly was of great importance among the counselors, preachers, and teachers, and of relatively little importance with the non-counseling visitor, the ritualists, and the community worker. Since the visitor and the community worker were Congregationalists and the ritualists were mostly Catholics, the denominational factor again is not the dominant one.

Conflict of Pastoral Counseling with Other Roles

One of the possible consequences of the emphasis on counseling as the central role is that conflict may occur between this and the symbolizing and congregational leader roles. In order to test this hypothesis, clergymen were asked, "What kinds of work did you do as a clergyman in the last week?" "Was this week typical?" "What kinds of work are most important for your ministry in this church?" "What is the importance of

pastoral visitation and counseling in your work as a clergyman?" Replies indicating irritation over the time consumed by one role at the expense of another—such as interference of worship services and administrative duties with counseling; or dissatisfaction with the role itself, such as the desire that the social work aspect of pastoral work be given to a trained social worker—were taken as evidence of role conflict.

Analysis showed that the least strain occurred when counseling was openly acknowledged as the central role, other central roles, especially preaching, having more strain. In actual figures, 3 counselors and 8 non-counselors reported strains, while among 6 counselors and 5 non-counselors there were no reported strains. Counseling, then, may be an adaptation to a society which is becoming more extensive and individualized. On the other hand, ritual as a central role also showed comparatively little conflict with other roles, so this role may be well adapted to highly stable areas in the society.

Integration of Pastoral Counseling with Other Roles

Counseling as a Means for Other Roles. In order to find out whether counseling was integrated with other roles rather than being in conflict with them, the question was asked, "What is the importance of visitation and counseling in comparison to your other work as a clergyman?" It was discovered that counseling was more a means for other roles than the other way around. It was used to make friends, to promote relationships between congregation members, to smooth over intra-congregational feuds, and to entice people to attend church who would not be attracted by the impersonal sermon alone. However, there was no difference between counselors and non-counselors in this respect. Seven counselors and 8 non-counselors made use of counseling as a means for other roles; 3 counselors and 2 non-counselors made use of other roles as means for counseling.

But, as already mentioned, neither set of clergymen saw much support given to counseling by the other roles. Thus when a clergyman says that counseling is the most important work he does, he does not mean that he is now performing the individualizing function of the secular professions, but only that there is a shift toward counseling as the society becomes more extensive and individualized and the needs for symbolizing and congregational fellowship decline.

Other Roles as Structural Substitutes for Counseling. Unlike the secular professional, the clergyman may have little need for counseling activities because for him they are often means of organizing a group of "clients," and for him other means of "client" organization are available. Visitation, for example, is a means of contacting members, even though its ostensible purpose may be counseling. However, visitation as a means of congregational integration is not used much. When clergymen were asked whether they were able to get around the entire congregation in

visitation, only 3 of the 9 counselors and 3 of the 13 non-counselors said that they were. Both tended to reserve their calls for illness, death, and other crises rather than for social visits or church business.

Other substitutes for counseling were found by asking those clergymen who did not reach the entire congregation by visitation, "How do you reach the rest?" Some used *personal* means of contact, such as the performance of private rituals (baptism, marriage, funerals, confession), church organizations, casual contacts before and after the worship services, and counseling. Others used *impersonal* means, such as visitation by assistant pastors or other persons, worship services, preaching, teaching, correspondence, and church bulletins or other periodicals. However, both counselors and non-counselors made approximately equal use of personal and impersonal means, 4 of each using personal substitutes for visitation, while 4 counselors and 6 non-counselors used impersonal substitutes.

Initiating Contacts with Counselees by Means Not Permitted to Secular Professionals. The clergyman's function as a symbolizer allows or even requires the clergyman to initiate contacts with counselees by modes not permitted to the secular professional. One would expect that counselors would act more like secular professionals in making these contacts whereas non-counselors would make more use of the modes of contact institutionally sanctioned for the clergy. However, there was no difference here, both making about equal use of professional and of clergy roles (9 and 8, respectively, for counselors; 12 for non-counselors).

In addition, few (2 counselors, 3 non-counselors) reported referrals from other professionals, and there was no real difference between them. Both made about equal use of contact in church organizations (5 counselors and 8 non-counselors) and in routine visiting (4 counselors and 10 non-counselors) as a means of taking the initiative with a "client's" problems.

However, when the question was asked, "What topics of conversation do you use in routine visiting?", it was found that counselors did relatively more unfocused, social calling (4 counselors, 2 non-counselors), while non-counselors did more focused calling with emphasis on personal problems of the "client" (0 counselors, 7 non-counselors). In this one respect, then, non-counselors violated the norms of the secular professional not to "pry unasked into the client's problems" and conformed to the norms of the clergy which permit or require this sort of thing.

The Congregational Fellowship—Its Effect on Counseling

Because the clergyman relies for financial support upon a congregation and often performs his religious functions by means of this fellowship of believers, it is questionable that he can have that extensity and impersonality of relationships which the secular professional finds so necessary in order to deal rationally with the personal problems of his

client. On the other hand, the religious leader, especially in Christianity, is expected to render equality of service to all human beings. Thus problems arise with respect to admission of non-members to counseling, initiating contacts with non-members, and relationships with counselees outside the counseling situation.

Freedom to Counsel Non-Members. That non-members should be included in pastoral care was agreed to by all 8 of the counselors and all 11 of the non-counselors who replied to this question. By way of explanation some said that this conduct was required by the very nature of a clergyman's role. Only a little mention was made by either set of clergymen of administrative or career motives such as attracting new members or obtaining publicity for the church.

Extent of Counseling Non-Members. Counselors, following the professional norm of universalism, rendered their pastoral services (including charity handouts) relatively more to non-members than did non-counselors (2 out of 7 counselors, 1 out of 9 non-counselors). Among the non-counselors the least professionalization appeared with the ritualists, for all 5 of those who reported said that they counseled non-members less. Eight of the 11 non-counselors in this group reported counseling fewer or no non-members; 5 of the counselors so reported.

Initiating Contacts with Non-Members. Although the roles of symbolizer and congregational leader give the clergyman some permission to initiate contacts with congregation members, he does not have so clear a sanction in dealing with non-members, who are in a position similar to that of the clients of the secular professional. How, then, are these contacts made?

It has been seen that both counselors and non-counselors relied equally on professional modes and clergy roles in dealing with members. With non-members, however, counselors emphasized professional modes (7 to 4), whereas non-counselors gave about equal emphasis to both (6 and 7).

But in other respects there were no differences in the ways in which these two sets of clergymen dealt with non-members. In the professional modes themselves it was, for both sets, counselee initiative rather than referral (counselors, 7 and 1; non-counselors, 7 and 1), the same as with members. It was the same with the roles institutionalized for the clergy, contacts occurring mostly through the request of or referral by third parties (relatives, friends, neighbors) (counselors, 3 and 1; non-counselors, 6 and 2). Perhaps the greatest distinction between members and non-members was that with the latter no clergyman used routine visiting, private rituals, periods before or after worship services, or community contacts, as he would have with members.

Relationships with Counselees Outside the Counseling Situation. Another consequence of the fact that the pastoral counselor has an organized group of "clients" is that counseling may be limited to those persons who have particularly close relationships with the clergyman inside and outside the church. However, both counselors (7) and non-counselors (7) reported that counselees tended to come from the lesser participants in the worship services and the church organizations. Three counselors reported the counselees "more participant" and 3 reported them as "equally participant"; the corresponding figures for the non-counselors were 2 and 3. Nor was counseling part of a large set of informal relationships with the clergyman outside the church. Of the 6 counselors and the 10 non-counselors who replied to the question, no one said that counselees had, before the counseling problem arose, more of such relationships than did non-counselees. Some clergymen of both sets said that the relationships were the same, but most reported fewer with counselees.

Perhaps regular participants were deterred from counseling because of fear of embarrassment. But only 1 pastor, a counselor, gave this as an explanation. Counseling, then, seems to be a substitute for other kinds of church participation and therefore is sought by the more isolated and mobile people.

Degree of Church Participation and the Ease of Counseling. As would be expected, counselors, being more concerned with individual differences, found the less active members to be relatively easier to counsel (4 reporting active easier, and 4 reporting less active easier), while non-counselors found the more active ones, the conformists, to be relatively easier to counsel (10 reporting active easier; 6 reporting less active easier).

But these were relative, not absolute, differences. Both sets of clergymen agreed that increased participation made for easier counseling, for with active participation the counselee knows what the clergyman is talking about, and the clergyman has knowledge of the "client's" background. In fact, the counselors were more positive on this point than the non-counselors, the latter tending to give other reasons such as faith in God and the expectation that the clergyman is obligated to counsel members. Four counselors said that active members were easier to counsel because of greater participation, as did a like number of non-counselors. However, no counselor ascribed the relative ease of counseling active members to other reasons, while 6 non-counselors did so. Thus the relative ease of counseling the less active was probably not because of the lack of close personal relationships but because the counselor had a greater professional orientation.

Further evidence of this professional orientation of counselors lies in the reasons given for the occasionally greater difficulty in counseling the more active members. Counselors were relatively more troubled by

the impersonal claims of the parishioners, such as demanding a large share of the pastor's time or regarding themselves as more righteous than the less active (4 out of 8 counselors; 1 out of 6 non-counselors).

"Scientific versus Religious Techniques in Counseling

An important aspect of the differences in professionalization of counselors and non-counselors lay in the use of "scientific" versus religious techniques. Counselors made greater use of "scientific" techniques, such as non-directive interviewing, permissiveness, hearing both sides of a dispute, and offering secular solutions and rational advice (8 out of 9 counselors; 7 out of 13 non-counselors), whereas non-counselors made greater use of such religious techniques as Bible reading, ritual, prayer, sacraments, penance, and confessional (counselors, 4; non-counselors, 8). This difference would be expected because the "scientific" techniques allow persons to enter the counseling relationship who are less indoctrinated with the religious beliefs of the clergyman, whereas the religious techniques allow for less attention to the individuality of the "client."

Conclusion

The hypothesis was set up that the latent function of the clergy is to help create the more limited and the more stable relationships in a society through such activities as ritual, preaching, teaching, and congregational leadership. The latent function of the secular professions, on the other hand, whose central role is counseling, is to help create the more extensive and the more individualized relationships. Consequently, when counseling is emphasized by the clergy as its central role, role strains should develop for the clergyman.

The study showed, however, that such emphasis on counseling *decreased* the clergyman's perception of strains between counseling and his other activities. This finding may indicate that counseling is an adaptation to a more extensive and individualized society whose needs cannot be met so well by the greater rigidity implied in ritual, preaching, teaching, and the congregational fellowship. Thus for the "client," counseling becomes a substitute for full participation in the worship services and the congregational fellowship; but this is true for both counselors and non-counselors. On the other hand, clergymen who see themselves primarily as counselors do report that relatively more persons outside the parish are included in the counseling.

A clergyman's emphasis on counseling cannot, however, be attributed to his failing to use other means of making personal contacts in the congregation, for no differences in this respect were found as counseling became emphasized as the central role. Furthermore, the counselor does not necessarily make greater use of professional means of initiating contact with counselees and less use of those means which are institutionalized for the clergy—especially taking the initiative with a "client's" problems.

Only in routine visiting did the counselor refrain markedly from making unsolicited inquiries into parishioner's problems.

What does stand out clearly is that clergymen who see themselves primarily as counselors make greater use of the more permissive techniques with respect for the ethical and religious individuality of the counselee, and less use of moral and religious indoctrination. It is not surprising, then, that these clergymen should experience fewer role strains, have less difficulty with marginal members, and even with their own parishioners be less troubled by relationships which extend beyond the counseling situation.

Under these conditions, then, where "clients" are marginal or nonparticipant in the parish, and where permissive techniques are used, emphasis on counseling will not result in role strains for the clergy. However, this emphasis does not imply that the central function of the parish clergy will become the individualizing one of the secular professional, for every society still has the more limited and the more stable relationships in the reference group and the fellowship. Indeed, it is possible that the technical rationality of the secular professional depends upon symbolizing and fellowship functions being performed, for himself as well as for his client, in other institutionalized areas of the society.

CHRISTIAN HEALING

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The Bible begins with the assertion that "in the beginning God created the heavens and the earth." And the first chapter of Genesis closes with the statement that "God saw everything that he had made, and behold, it was very good." Here, I believe, we have the most succinct Biblical statement of the authentic Christian view of the world and the flesh: They were created by God and they were "very good." Such a world-view underlies all the writings of the Jewish Scriptures, and it is repeated and underscored and even sharpened in focus in the writings of the New Testament. In the specifically Christian Scriptures we are told by a number of authors, but notably by Paul, by the Johannine writer, and by the author of Hebrews, that he who was God's eternal Son, "through whom all things were made"—indeed who "was God" also himself—"became flesh and pitched his tent among ours." And this One who "was God" and who "became flesh," when he would leave a perpetual memorial of himself on earth, took bread and wine from the supper table and called them his flesh and blood.

All this is by way of emphasizing that authentic, Biblical Christianity looks upon the flesh, and upon all material things, as none other than the holy creation of God, fit to be the tabernacle of his Son on earth, fit to be the symbols of his Son's abiding Presence in that holy fellowship which is his Body the Church.

Christian healing, then, like anything else which presumes to claim the Name of Christ, accepts the reality and the God-created goodness of flesh and of all matter. Christian healing does not despise the material or deny the reality of the flesh, for the Christian does not presume to be more spiritual than God.

Sometimes it is easier to make a definition by stating what a thing is not before trying to say what it is. I believe that Biblical Christianity forbids us the Gnostic blasphemy of denying the reality of the tangible world. All systems and theories, then, by whatever ancient or modern name they go, which seek to heal man's body, mind, or spirit by denying the existence of any one of these are not Christian at all. The most familiar and perhaps the most respectable of these systems is so-called Christian Science. Today there are a host of popular imitators—New

Thought, Religious Science, Divine Science, and Unity, to name a few. These all use the Name of the healing Christ in their literature, and I say "use" advisedly. For there is one common thread running through all these various systems: They seek to place the power of Almighty God at man's disposal. This of course is the essence of magic, and it is the exact opposite of authentic religion in which man seeks to be the willing servant of God.

In the historic Communions there is also a revived interest in what is usually called "spiritual healing," the Protestant Episcopal Church being a conspicuous example. Some of this activity is in the Biblical tradition of The Letter of James:

> Is any among you sick? Let him call for the elders of the church, and let them pray over him, annointing him with oil in the name of the Lord; and the prayer of faith will save the sick man, and the Lord will raise him up; and if he has committed sins, he will be forgiven. Therefore confess your sins to one another, and pray for one another, that you may be healed. The prayer of a righteous man has great power in its effects. (5:14-16)

But all too often there is a typically priestly preference for prayer in place of medical treatment. In the words of a nationally known Episcopal priest who conducts large and frequent "healing services," "We are not interested in diagnosis." The leaders of "spiritual healing" movements usually speak kindly of physicians and surgeons, but all too often there is a kind of crypto-Gnosticism and priestly arrogance in their subtle implication that God is the real Healer, not the doctor, and that the minister is always—and the doctor seldom—the servant and spokesman of God.

Among some other denominations there is considerable activity in what is called "faith healing." We are all familiar with the way in which these faith healers operate. They thrive on publicity and mass enthusiasm, and they invariably use a great deal of suggestion with both their patients and their audiences. All of this seems to be in sharp contrast to the healings done through Jesus, who sternly forbade publicity, who healed the patient quickly before a crowd could gather, and who sometimes failed to heal because the patients lacked faith, and he would not force them to appear cured by using the power of suggestion. This so-called "faith healing" is not really based upon faith in the Healer of Galilee but upon faith in the showman. It has the appearance of godliness but lacks the essence of it.

Perhaps the most respectable form of healing that purports to be Christian is that which utilizes the findings of psychology and psychosomatic medicine (which are of course quite sound and genuine) and seasons them with prayer, Bible verses, and case-history type anecdotes. An excellent example of what I mean is to be found in the January 1959 issue of the magazine *Science of Mind*. This article is called "Pills and Prayers" and is written by a physician, Alfred J. Cantor, M.D., President Emeritus

of the Academy of Psychosomatic Medicine, author of *A Handbook of Psychosomatic Medicine* and editor of *The American Journal of Proctology.* His medical soundness is beyond question. But when he assumes the theologian's mantle, it proves to be very poor fit. He equates faith with autosuggestion, and feels that many ills *can* be cured by prayer and faith because they have been brought on in the first place by a lack of love and confidence. His article closes with these words:

> Effective prayer, prayer which has salutary physical results, might be considered the same as the placebo with its favorable effects, but without the bother of taking the placebo. The patient just knows he is going to get better and better he gets.
>
> Regardless of whether the physician gives a patient an active drug or a placebo it might also be wise for him to furnish a prayer which the patient could use, for apparently any result which appears will to a large extent, depend upon what the patient thinks.
>
> Perhaps the time is coming when pills and prayers will be prescribed together. In any event, according to the times in which we live today, if a patient takes a pill, he should also say a prayer; he should have faith and affirmatively state that the pill he is taking will effectively accomplish that for which it was prescribed. It is the patient's faith that he is going to get better that is an important determining factor. He has to mentally accept health in order to experience it.[1]

Now this is very sound psychology, but a man could be an atheist and use the same system of autosuggestion to insure that his whole being would rally its built-in repairing factors and hasten the healing process. This is Christian healing only in the same sense that saying 2 plus 2 equals 4 is Christian arithmetic. We must be very insecure about our Christian convictions if we are so uncritically enthusiastic about every kind word tossed our way by an M.D. I believe that Christian healing is a more profound concept than the use of autosuggestive prayer to heal oneself.

Our primary source for a definition of Christian healing is to be found in the Synoptic Gospels. I would rule out the Fourth Gospel, not because the healings described in it are harder to credit, but because the writer (it seems to me) is frankly using the narrative of a healing to illustrate the redemptive power of the Christ who is with us always, even to the end of the age. I believe that in the Synoptics we get less of an artist's interpretation and more of the candid camera's unposed scene.

In the first three Gospels Jesus returns from his own inner struggle in the wilderness and begins to proclaim the good news of the kingdom of God and to heal all kinds of sickness. Mark and Luke tell us that his first healing was of a mental patient in the synagogue at Capernaum. The same day he cured Simon Peter's mother-in-law of a fever, and that evening he

[1]Quoted with permission from *Science of Mind,* January, 1959.

restored to health a large number of people, both the physically ill and the mentally ill. Matthew and Luke say that he healed all who were brought to him. Perhaps Mark's tradition allows for those who had not the will to get well, for Mark says that "they brought to him *all* who were sick or possessed with demons . . . And he healed *many* who were sick with various diseases, and cast out *many* demons" (1:32 and 34). Again Mark notes Jesus' lack of success when he returned to Nazareth: "And he could do no mighty work there, except that he laid his hands on a few sick people and healed them. And he marveled because of their unbelief" (6:5 and 6). And it is Mark also who gives us the story of the blind man of Bethsaida, how Jesus restored his vision in private, using a material substance and achieving the healing by degrees: "And they came to Bethsaida. And some people brought to him a blind man, and begged him to touch him. And he took the blind man by the hand, and led him out of the village; and when he had spit on his eyes and laid his hands upon him, he asked him, 'Do you see anything?' And he looked up and said, 'I see men; but they look like trees, walking.' Then again he laid his hands upon his eyes; and he looked intently and was restored, and saw everything clearly. And he sent him away to his home, saying, 'Do not even enter the village' " (8:22-26).

Take out the healing stories, and there would be little left of Mark except the Passion narrative. Yet it seems as if Jesus heals only because he is the Herald of the kingdom of God, and when people come to him convinced that God is King and wanting God's kingdom within them, Jesus becomes the Restorer of that original wholeness and orderliness which God gave man at Creation. Yet Jesus seems to be seriously concerned lest his primary work of proclaiming God's kingdom be deflected by the claim made on his time and energy by those who want a healthy body or a sound mind but do not hunger and thirst for the righteousness of the kingdom of God. So Mark tells us that before daylight the morning after he had cured many people in Capernaum Simon and his friends discover Jesus seeking God's renewing strength in privacy and prayer, and they say to him, "Everyone is searching for you." But he seems to reject the role of healer for that of prophet, and he replies, "Let us go on to the next towns, that I may preach there also; for that is why I came out" (1:35-38).

If Christian healing is to be like Christ's, then, it must be more than using religious devices to achieve mental or physical health. Jesus looked upon God as Father and King and therefore as One who both desired men to be whole and had the power to make them whole, if they would accept him as Father and King. We too often look upon God as an unknown doctor whom we telephone in an emergency, demanding that he make a house call; or, what is worse, we conceive of God as a sort of magical pharmacist who is always there, docilely waiting to fill any prescription which we, the doctor, decide to write out.

The command Jesus gave to the Twelve is surely binding upon us as his disciples: "Preach as you go, saying, 'The kingdom of heaven is at hand.' Heal the sick, raise the dead, cleanse lepers, cast out demons" (Matthew 10:7-8). The pattern is the same as the one he himself followed: Proclaim the immediacy of God's kingdom, and then in evidence of that restore men to life and health. We preachers are proclaimers of God's claim of sovereignty over every human being. It is our conviction that our God is every man's King and Father that makes us pastors, shepherds of the sheep of his world-wide pasture. He wills the sick to be well, the dead to revive, the outcast lepers to be cleansed and received again, the tormented minds to be restored to creative orderliness. And because He wills it, we must will it and work for it.

Healing is Christian when it is motivated by love and compassion on the part of the healer and by a sincere desire to serve God, with all the responsibilities that go with health, on the part of the patient. I believe that such an approach to healing *is* Christian even when the Name of Christ is not invoked, for the authentic spirit of Christ is actively present. This is a far different thing from that approach to healing which freely uses the Name of Christ and the various implements of religion, but yet is motivated by pride on the part of the healer and only by a desire to enjoy health on the part of the patient.

PASTORAL DECISION: TO COUNSEL OR REFER

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One of the most valuable clues to the severity of mental or emotional illness is revealed by the patient's pattern of adjustment. It is with patterns of adjustment that we are primarily concerned since such patterns influence the choice of treatment and assist in determining whether treatment should be by a specialist in mental illness or by a pastor, a family physician, or some other professional person. Patterns of adjustment or maladjustment also affect the prognosis of treatment.

We are concerned not only with the rigidity or flexibility of this pattern but with whether or not a particular way of relating to other people is evident in the home, in the school for a school-age child, on the job for the adolescent or adult, and in social relationships of both children and adults. How widespread is the pattern? Repetitive actions, feelings, and attitudes (patterns) are not under the conscious control of the patient. In some cases, the pattern of adjustment within the family may be vastly different from that seen by individuals who have social contact with the patient. If so, this is an important factor to evaluate.

Patterns of behavior, which result from underlying feelings and attitudes, are revealed through information about the patient's interpersonal relations within his family, with other relatives, with neighbors, with employer and fellow employee, or in school. What are the patient's social, cultural, and economic standards, his daily habits and routines, the condition of his physical health? Knowledge of these various factors results in an evaluation of the patient's habitual way of adjusting. Such knowledge assists in understanding how mentally healthy or mentally ill the patient may be.

The pastor, like the family physician, the public health nurse, the welfare worker, may know many of these things before the patient or the patient's relatives seek help from him. He will obtain additional information from the patient's own story. In a case of acute psychotic disturbance, the patient himself will probably be unable to provide information, which may of necessity come from other persons. These other persons may be more objective, but their story will be colored by personal

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feelings toward the patient. In some instances, relatives may be seeking help and reassurance in having the patient committed to a mental hospital.

Other clues to the severity of illness, with the possible need for referral to a specialist, concern the onset, duration, frequency, and precipitating factors in the patient's illness. Precipitating factors are usually relationships which stir up emotions such as grief, anger, guilt, or feelings of helplessness which the patient is unable to express. These emotions are frequently due both to external and internal stress. Disturbance is far less likely to result from emotions that are brought out into the open. Feelings and attitudes that are disturbing are seldom new but are old ones which may have accumulated over a period of time, or may have been precipitated by some particular episode. The result may be inadequate functioning on the part of the patient.

At this point it might be well to mention that, although most therapists and counselors would like to know exactly what is "wrong" with a patient, i.e., understand the etiology of his illness, the main purpose in counseling is not our own understanding or "insight," nor is it primarily to help the patient "gain insight." Patients can be, and frequently are, helped without the counselor's understanding the deep underlying causes of the patient's illness. An individual may develop "insight" into the causes of his own illness and still remain ill. Both the counselor and patient may develop "insight" and the patient may remain ill.

Each patient needs careful individual evaluation. What may be supportive to one may be destructive to another. In some situations it is essential that there be no probing into etiological factors, and preoccupation with deep, complex psychopathology should be avoided in discussion with the patient. It is quite true that search for the origin of the patient's difficulty is a part of therapy but many times the area of "search" is deliberately and specifically limited, with focus maintained on the development of the patient's potential for constructive activity. We frequently speak of the psychotic as behaving unrealistically or "losing touch with reality," of the neurotic as "distorting reality." We may speak of treatment as helping a patient "face reality," but sometimes his reality is so frightening for the patient that even the psychiatrist does not work toward "insight." If we adhere too closely to this idea of helping the patient "face reality," we may not provide him with sufficient emotional and environmental support and he may withdraw from counseling.

Dr. Kenneth Appel, of the Department of Psychiatry, University of Pennsylvania, has said that "psychotherapy is helping individuals find outlets for their energies, their impulses, their activities, which are reasonably satisfying and constructive in the long run. Such therapy is not merely an intellectual discussion. It is not just reasoning and explanation."

Emotional and environmental supports begin to exert their influence at birth and continue throughout life. The pastor is in a particularly

strategic position to exert his influence not only on the patient, but on the environment consisting of the family, the school, the job, the community. He is in a position to help neutralize anxiety in the family, to assist the family in being more comfortable with the patient and the patient with them. Since anxiety is infectious, helping the family, the school, or the employer to be more accepting and tolerant of a patient who has returned from the mental hospital, for example, may be the treatment of choice. It is these day-by-day relationships that are vastly important as they will provide the outlets for the patient's energies, activities, and impulses which Dr. Appel mentioned. Counseling with patients and families should not attempt to remove all frustrations or to eliminate all unpleasantness but should be aimed at channeling attitudes, feelings, and behavior into directions which will give the individual a more satisfactory adaptation.

Every person has positive strengths even though he may need help in seeking out opportunities for growth and development. We tend to look for weaknesses, for pathology, in the individuals who seek help through counseling. It cannot be emphasized too strongly that it is the strengths we work with. Evaluation of strengths results in a composite picture which provides us with an impression of the patient's personality. An alert, sensitive counselor is making this evaluation as he explores the patient's pattern of adjustment and discusses the onset and duration of the patient's distress. He watches for signs of anxiety and depression, both of which are present in many of the more serious mental illnesses as well as in the lesser emotional disorders, but he must watch just as carefully for signs of adequate handling of anxiety and depression. A wise counselor supports a good, strong relationship that the patient has with someone and helps him talk out an angry, hostile relationship. He makes his diagnostic evaluation by positive signs of strength, not merely by exclusion or absence of some signs of weakness.

It is only when anxiety becomes overwhelming that it results in inefficient functioning since, within limits and sufficiently controlled, anxiety aids the individual in establishing healthy defenses. If, in spite of pastoral counseling, anxiety continues as a threat to the patient's total health, to his adjustment to family, work, and community, the pastor should consider consultation with a psychiatrist. There is no point in giving advice to a patient if he cannot follow it. If the anxiety manifests itself physically as well as verbally and in behavior, and the patient is told to "relax," he may feel misunderstood and may lose confidence in the pastor's ability to help him and may later resist accepting referral to a specialist. Anxiety is usually only a part of the total symptom complex. If the patient is not overwhelmed, though he is uncomfortable, and is able to continue with regular interpersonal relationships without drastic change in attitudes and behavior, he is probably a good candidate for pastoral counseling.

Depression is another symptom frequently found in the more serious

and in the lesser mental illnesses. Dr. Manuel Pearson, of the Department of Psychiatry, University of Pennsylvania, has estimated that only 25 per cent of the mild depressions get to a psychiatrist, leaving 75 per cent in the hands of family physicians, ministers, and other professional persons. He has also pointed out that suicide is the ninth leading cause of death in the United States but thinks it may be even higher because the stigma attached to suicide may sometimes lead to some other diagnosis being placed on the death certificate.

If a depression is mild, acceptance and understanding, reassurance and encouraging support may help the patient overcome the depression. If it persists after a week or two of such attempts, the pastor should probably seek consultation. In cases of depression, it is important that the patient be seen frequently, that he not feel rejected by indifference or any hint of moralizing. The ability of the patient to keep working, even though depressed, may be a measure of strength, and he should be encouraged to continue on the job if possible. If there is persistent and excessive loss of weight and continued insomnia, consultation with a psychiatrist is definitely indicated. The depressed person is frequently a perfectionist, who has to have everything "just so," who may feel guilty if he cannot operate in such a way that he can arrange his life "just so," who may be uncomfortable and guilty if he is angry at other people.

Psychosomatic complaints, i.e., physical symptoms in addition to disturbances of feelings, attitudes, thoughts, and behavior, are frequently expressed by the patient seeking pastoral counseling. Such illnesses usually need treatment which combines medical supervision with counseling. By working closely with the family physician, who may have treated or may be treating the patient, the joint efforts of the pastor and physician may prove beneficial. In some cases the pastor may refer the patient back to the physician for both counseling and medical care but may be the main source of support for the family.

If referral is made to a mental health specialist, the pastor does not continue counseling about the same problems with which the specialist is dealing. If the patient continues a contact with the pastor, the pastor encourages the patient to take these problems to the specialist. The pastor may, at the same time, work with the family.

In summary, the primary measure of whether a patient needs to be referred to a psychiatrist or will respond to pastoral counseling, i.e., helped to meet daily problems as they arise in order to maintain at least a marginal standard of adjustment, is the patient's life pattern of adjustment. If the patient has consistently reacted inadequately, with poor judgment, with emotional storms, or with so-called "acting-out" or destructive behavior, to most of the stresses and strains he has met in a lifetime, he is not likely to be able to change his pattern of adjustment as a result of counseling with an interested person and even as a result of therapy with a psychiatrist. One needs to review this life pattern in

terms of actual performance, as to adequacy or inadequacy to meet stresses, as to emotional disturbance, as to the ability to make constructive changes, however slight, and also as to possible indications that there is no real feeling for others or an ability to make "good" interpersonal relationships even though the patient's words belie his actions.

If the inadequacy is paramount, supportive therapy is indicated and referral is not necessary. If the emotional disturbance is slight, referral may not be necessary and a good counseling relationship may be all that is needed. If the emotional disturbance is severe, psychiatric skills may be essential. If the patient shows, during pastoral counseling, some ability to make constructive changes, these assets can be capitalized on and referral is not necessary. If the sociopathic tendency, the inability to form personal relationships and complete egocentricity, is present, then it is best to leave the patient alone because neither pastor nor psychiatrist can help him either through spiritual means or currently known scientific methods in psychiatry. There can always be the exception, but the percentage is not high.

A second point of importance is the onset, duration, frequency, and precipitating factors in the patient's illness. If the onset is sudden and the emotional disturbance is severe, referral to psychiatric sources is certainly indicated. If the onset is acute and involves only a specific problem or incident, it can usually be handled with sound judgment, equanimity, and support. If the onset is insidious, with small changes apparent over a long period of time, psychiatric help is definitely necessary. Repeated attacks of mental illness or emotional disturbance also point toward psychiatric help, whereas a first attack or incident can often be resolved with quiet understanding and counsel.

A third essential in counseling is to remember that "insight" on the part of the patient and counselor is not necessary for the patient to be helped. Dealing with positive strengths in the patient and his ability to adjust can often be much more helpful than delving into the depths of the patient's psychopathology. Finding outlets for energies, impulses, and activities can often be much more constructive than the intellectual pursuit of etiological factors.

The fourth, and possibly the most important, factor in pastoral counseling is that the clergyman is able to allay anxiety in the family. He helps to do this in his daily and weekly contacts with the family.

Lastly, one looks for strengths rather than weaknesses and capitalizes on these strengths. It is better to look forward than it is to look backward, even though looking back may help to understand etiology. A positive approach to a patient is more valuable than a negative one. The only word of warning in closing is that, because of enthusiasm, a need to find the positive and to help, the counselor does not suffer from the astigmatism of his own eagerness.

RELIGION AND MENTAL HEALTH

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In the history of medicine, psychiatrists and religious institutions have not always agreed in their goals or methods. On the contrary, about 400 years ago, the mentally sick patient was believed to be possessed by the devil's spirit and was treated accordingly. The methods of psychiatry were restraint, torture, and complete isolation (2).[1] Nothing, it was believed, could help these unfortunates, and the best treatment was to keep them far away from other human beings. In modern times our outlook and knowledge about the mentally ill have changed, and the treatment has been modernized according to our learning through observation and experience. The air of secrecy and restraint has been replaced by sympathy and understanding, leading to the study of rehabilitation of the mentally sick, and finally enabling their return to family and community life.

We still do not know enough about the causes of mental sickness, and the theories of psychiatry are different and often contradictory. However, in two points religion and psychiatry agree. First, that the family is a very important factor for the cause and rehabilitation of mental sickness, and, second, that mental sickness is precipitated by stress and strain. Nobody can escape that. The economic conditions, the struggle for life and existence, are hard and cruel for the majority of us, and the human being has to be strong physically and mentally in order to resist. Many unnecessary problems, however, are created by ourselves, and it is a fact—which we always find in the history of our mental patients—that the family background, harmony or disharmony in the family life, is vitally important to mental health. Divorce and separation of parents is one of the most frequent findings in the history of juvenile delinquents and young schizophrenics; negligence from one or both parents, frequent changes of surroundings or location following divorces, quarrels between the parents, hate and jealousy of stepfathers or stepmothers, and foster homes without love and understanding are very often the causes for the

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[1]Numerals in parentheses refer to items in the list of references at end of article.

precipitation of mental sickness. Fathers coming home late at night from drinking sprees, mothers interested in other men, and economic and social ruin following these strivings are the center of many of the problems of the mentally ill. The influence of heredity is still there, but it is not as important as it was once believed to be.

To keep up and to maintain the sound foundation of family life is, therefore, one of the common goals of our religious leaders and of preventive psychiatry. Psychiatrists, today, are aware of the fact that an individual has to be considered as part of the entire family and its environment (1).

Another fact, so very important for religion and psychiatry, is the belief that nobody can be a useful member of mankind and a mentally healthy person, when not in control of the instinctive drives born in us and with us. The drive to sadism, so often observed in children, egocentricity, lack of obedience, and the will to do what we want and what we are pleased to do have to be replaced by socially accepted forms of living, by the understanding of our neighbors, by the sympathy for the suffering of mankind. Religions, through the words of great teachers, foster this idea. Psychiatry, by scientific study, believes that repression is necessary for all men to overcome the "Id" or the instinctive drives of hate and destruction. It is the principle of love against hate, as Karl Menninger (6) has so succinctly pointed out. As long as we feel that the forces of hate in us are predominant, we cannot be considered as mentally healthy. Therefore, the goal of religious institutions and of psychiatry is the same: both teach that we will not be able to grow up, to overcome our emotional immaturity, unless the "Superego," or let us call it our conscience, helps us in the repression of our instincts which are not bad in themselves, but need guidance and direction.

The methods of religious institutions and those of modern psychiatry may differ and be open to criticism, but the goal always has been the same and always will be.

Psychiatrists and religious leaders did not always understand each other. When Sigmund Freud published his book, *The Future of an Illusion* (3), there was—among religious circles—a current of distrust and criticism of psychiatry. Freud, in this book, expressed some ideas now held in esteem in communist countries. He thought that religion might be damaging to mankind because it promises a life after death, a paradise fulfilling all our wishes. Therefore, humanity might not struggle against suppressing rulers, but might, on earth, accept everything with patience and obedience. These ideas of the founder of psychoanalysis can be explained only historically: Freud lived in Vienna, the capital of the Austro-Hungarian empire, at a time when freedom of ideas was not permitted, and any criticism against the aristocratic clan was considered a crime. Furthermore, Freud himself suffered a great deal because of discrimination against

the minority to which he belonged. If he had lived in the United States this idea would not have come to him, because in this country of freedom and democracy criticism and open discussion on every subject are permitted. Indeed, in our country, psychiatrists and members of all religions work together. Many psychiatrists are seeking collaboration with religious representatives and are firmly convinced that faith is an important factor in problems of emotional health. Many experiments have verified that Alcoholics Anonymous has obtained better results in treating those suffering from alcoholism than have psychiatrists with modern drug therapy or even psychotherapy.

Many psychiatrists today generally agree with the idea of Emanuel Kant, the great German philosopher, that, although we have no scientific proof that God exists, His existence is morally certain. In the whole field of medicine, faith can, indeed, do much for the healing process, physically and psychologically. I remember well, in my own clinical experience, the case of a 40-year-old patient who suffered from active tuberculosis with cavities in his lungs. The specialists had given up hope, and had told members of the family that the patient did not have long to live. But the patient did not give up; he believed in his recovery; he struggled very hard against his sufferings; he wanted to live by all means; and he had faith in God. After three long years of suffering he started to feel better, the cavities became smaller; he improved; and at the present time he is well again and working normally. The tubercular process has been arrested.

Books have been written about miraculous cures in many countries, about men or women with special healing powers, about Lourdes, France, and other places, where suffering improved and many were able to walk again after a partial or total "paralysis" of their limbs. The miracle in therapy, indeed, has become an important factor in modern medicine. Not everything can be explained readily by hypnotic influence, by suggestive methods, by autosuggestion, and so on. Buddhists, for instance, believe in the connection of certain factors of life and reincarnation. They think that the feelings of sympathy and antipathy against a person we meet for the first time, or the feeling that we have seen this or that place before, without remembering when, are related with the idea of a former life and being reborn after death.

All this is not scientifically proved, but psychiatry and medicine as a science think that emotional factors are involved in every case of sickness, physical or emotional. Psychosomatic medicine, as related to the experience and experiments of Grinker (4), Weiss and English (7), and others, confirms the importance of the psychological factors in such sicknesses as high blood pressure, chronic arthritis, stomach ulcers, and many others. Emotional factors are of great importance in regard to origin and treatment of most sicknesses.

Another vital point to consider is our motivation. A. H. Maslow (5),

an outstanding psychologist, describes the basic needs of all men and comes to the conclusion that all human beings have not only physiological needs to maintain a constant and normal state of the blood stream, a certain acid-base balance in our organism, and certain vitamins, but psychological needs, too. Our psychological needs include safety in connection with threats and dangers, disabilities, unemployment, needs for self-actualization and self-fulfillment (a tendency for every individual to do what he is best fitted for), needs of esteem, prestige and self-respect, and, most important of all, needs for belongingness and being loved. Every individual suffers from absence of love, not only in the circle of his own family, but among his neighbors, his friends, and in his community. This involves the giving and receiving of love.

This is where members of every religious organization and of every medical society can and should meet on common ground. The feeling of being rejected by members of the family and by the community, the feeling of not being accepted, of being a burden, of being considered useless, superfluous, ridiculous and not understood, is one of the most common stresses causing emotional disturbances and contributing to physical illness. When a person feels unhappy, unloved, the first step to mental sickness has been taken, a step which may eventually bring the individual to the mental hospital, suffering from depression, anger, resentment, and emotional instability. As resentment grows it may even cause delinquent behavior in children.

In these cases the psychiatrist alone, working in a hospital or in office practice, cannot help the patient. The patient may get all the love he needs in the hospital, he may be helped in his feelings of safety and self-esteem, but our work should not end when he leaves the hospital and returns to his family or his community. The work of rebuilding, of reforming, of giving love and understanding has to be continued on the outside, and ministers, priests, and rabbis can do a very useful and necessary work for and with the patient after he is released from the hospital.

Today psychiatrists agree that much can be done by prophylaxis, too. Many individuals might never have become patients in a mental institution if they had found, before hospitalization, sound psychological advice on the outside. Members of the family are frequently unable to give this kind of advice because they are not objective enough or are too emotionally involved. But prophylaxis can be done by the heads of religious institutions, especially when they have some training in recognizing and handling emotional problems. Many of these problems can be improved by "common sense," but some study and learning is surely helpful. For this reason, a considerable number of psychiatric institutions, in our country and all over the world, are now introducing special courses for student chaplains wherein they work with the psychiatrist toward a common goal: to help emotionally disturbed individuals in the hospital as well as in the community.

However, the difference between psychiatric treatment and advice given by a religiously trained representative of a church organization should not be overlooked. Real psychiatric treatment belongs to the trained psychiatrist, who knows the physical and emotional factors involved in an emotional disturbance. Some emotional sicknesses, like psychoneurosis, require special training in psychotherapy, and treatment may last a couple of years. The more severely "mentally sick" patient should be handled by professionally competent persons only, and unrealistic or untimely experiments in treatment might do more harm than good. The psychological difference between a psychiatrist and a religious therapist can, at times, be great.

Some religious therapists are occasionally intolerant when they have to deal with persons suffering from chronic alcoholism or with immature psychopaths and consequently recommend too much strictness. All psychiatrists agree that a tolerant attitude and flexibility are vitally important for the treatment. Sometimes in severely depressed persons, suffering from a too severe conscience or Superego, the goal of treatment has to be one of helping the patient to decrease his punishing Superego, to relax, and to be less compulsive. Such a goal is not easily achieved and maintained.

Still another factor to be considered in the treatment and understanding of the psychiatric patient is the necessity of the therapist to have had adequate experiences in his own life, such as marriage and family responsibility. We also have to be aware of our own unconscious drives to be hostile or to destroy. An individual who has had such experiences in his own life might be better able to understand certain conflicts in an emotionally disturbed person.

The different viewpoints and difficulties can be overcome by training and experience and should not impede a more extensive cooperation between psychiatrists and religious leaders. Both try to help persons in trouble and misfortune, and special techniques are not always required. Faith in ourselves, in the essential goodness of men, in goal-directed life, and in the creative powers is a necessity. These creative and constructive powers are present in every individual, but they are sometimes deeply hidden, or temporarily overcome by the wish to destroy oneself or others. Without faith, nobody is able to help others.

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THE LEARNING OF EMPATHY: A PILOT STUDY

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Whether the acquisition of empathic ability is a legitimate aim of educational procedures and techniques is perhaps a moot question. Certainly the emphasis placed upon such a goal would vary considerably with one's particular philosophy of education and upon the specific area of educational concern.

However, despite any thoroughgoing establishment of complete agreement relative to the importance of empathy in education, there appears little doubt that empathy represents one of the salient keys to the understanding of one's fellow men.[1] It is difficult to discover a solid area of agreement as to exactly what empathy is or how we are to measure it, but there is certainly a high degree of agreement as to its importance. The empathic response has been shown to be exceedingly important in such areas as anthropology, prejudice, education, counseling, and psychotherapy.[2]

Most researchers assume that empathic ability is amenable to training, though specific and systematic illustrations are lacking.[3] The present paper represents an attempt to measure variations in emphatic ability before and after a specific kind of educational experience, namely, clinical pastoral training.[4]

Subjects and Procedure

The subjects of this study consisted of 18 male theological students

[1]L. S. Cottrell has referred to empathy as the "basic process" in all social interaction. See "The Analysis of Situational Fields in Social Psychology," *Amer. sociol. Rev.,* 1942 VII, 370-382.

[2]Strunk, O., Jr. "Empathy: A Review of Theory and Research," *Psychol. Newsltr,* N. Y. U., 1957, IX 47-57.

[3]Kandler and Hyde did measure increase in empathic ability in the training of nurses during psychiatric affiliation and found a significant increase in empathy during eleven weeks of training exposure. See Kandler, Harriet M., & Hyde, R. W. "Changes in Empathy in Student Nurses during Psychiatric Affiliation," *Nurs. Res.* 1953, II (1), 33-36.

[4]For some suggested areas of research in regard to empathy in the clinical setting, see, Strunk, O., Jr. "Training of Empathic Abilities: A Note," *J. Pastoral Care,* 1957, XI, 222-225.

and parish clergymen.[5] The mean age of the group was 28 years with a range of 22 to 52 years. These subjects were registered in a 12-week course of clinical pastoral training in a mental hospital.[6] They participated in the course five days per week, from 8:30 A.M. to 5:00 P.M. They were exposed to a rather intensive sort of training consisting of counseling relationships with patients, lectures, readings in the areas of psychology and psychiatry, group dynamics, interviews with supervisors, and periodic evaluation of work.

During the first week of training the subjects were given *The Empathy Test,* Form A.[7] This is an "objective" test in the sense that "correct" responses are based on empirical findings. Briefly, the individual is asked to rank various areas according to a specified orientation. For example, the question, "What does the average American choose to read?" is followed by a listing of fifteen different popular magazines with the instructions that the subject rank them according to circulation. The subject's ranking is then compared with actual or true ranking, based on empirically determined circulation figures, the difference yielding an empathy score.

The subjects were asked to take the test in order to help out in a piece of research. During the last week of the course the test was again administered.

Results

The before and after scores of each subject may be found in Table 1.

TABLE 1

SCORES OF 18 THEOLOGICAL STUDENTS ON *The Empathy Test* BEFORE AND AFTER CLINICAL EXPERIENCE

SUBJECT	BEFORE	AFTER
1	123	103
2	95	77
3	87	92
4	87	88
5	83	95
6	83	81
7	81	89
8	80	85
9	79	88
10	78	61
11	77	73
12	76	95
13	75	95
14	73	95
15	67	67
16	59	83
17	49	73
18	49	67

[5]Three additional students took part in this course but complete data were not available on these students.

[6]The authors would like to express appreciation to Chaplain Judson D. Howard of the Boston State Hospital for permission to conduct this study.

[7]Kerr W. A. & Speroff, B. J. The Empathy Test. Manual of Instructions. Chicago, Ill.: Psychometric Affiliates, 1951.

Seen from the point of view of difference between means, no significant increase in empathy took place during the training period ($t = 1.23$). This is partially explainable in terms of the scores of Subjects 1 and 2, both of whom scored exceedingly high on *The Empathy Test* during the first week but dropped considerably toward the end of the course. Correlational examination of the raw scores indicates a positive relationship between before and after scores, with an r of .545.

Scrutiny from the point of view of increases and decreases in scores indicated that 12 of the 18 students *increased* in empathic ability, as measured by the research instrument; five decreased; and one remained the same. A Sign Test[8] resulted in a p of .072, which is highly significant, indicating general increase in empathy scores for the group.

Discussion

The small size of our sample does not permit us to make any kind of legitimate assertion, nor does our instrument permit us to say *with certainty* that empathic ability increases with exposure to clinical pastoral training. Despite these obvious limitations, however, our data do permit us to suppose that exposure to intense interpersonal relationships, under supervision, leads to an increase in the ability to empathize, as measured by *The Empathy Test.*

Also, our results tend to support those researchers who assume that empathic ability is amenable to training.

But perhaps more important still is the raising of certain hypotheses and questions stemming from the study, especially in regard to *decreases* in empathy scores—for decreases in empathic ability, especially as illustrated in the case of Subjects 1 and 2, poses a perplexing problem. However, when we turn from the statistical evaluation to that of clinical analysis, this perplexity is partially resolved.

One of the authors (KER) developed a close relationship with four of the five subjects who dropped in empathy scores. Two were in a group dynamic seminar led by KER, and two had their student-patient relationship supervised by KER. Each of these four subjects demonstrated a severe conflict with authority. According to the other subject's supervisor, he, also, experienced conflict with authority.

Due to the limitation of our study, we are reluctant to draw conclusions. However, there are certain hypotheses that we shall set forth from a clinical viewpoint that might possibly explain why Subjects 1 and 2 decreased in empathic ability.

First, it is possible that Subjects 1 and 2 were giving up selves in favor of a greater value, i.e., group unity, feeling, and cohesiveness. This does not seem out of line with emphases in the program. Intensive group dynamic

[8]Siegel, S. *Nonparametric Statistics.* New York: McGraw-Hill, 1956. Pp. 68-75.

sessions (one and one-half hour in length three days per week) constitutes a major emphasis in the clinical training program. Rollo May writes, ". . . as counselors we must learn to empathize . . . learning to let one's self go into the other person with a willingness to be changed in the process. It is a dying to one's self in order to live with others."[9] Perhaps the sharp decrease in these subjects reflects movement toward a group mean that would in turn reflect the overcoming of individual differences in favor of a group feeling and movement. They put the group above self.

Secondly, many writers seem to imply that empathic ability naturally assures a positive, healthy relationship. Clinically, we do not always see this happening, although empathy is essential to good relationships. Sullivan writes of empathy as being an "interpersonal process." Just as one perceives a sense of security, warmth, and positive feelings in another, likewise one perceives, by the same process, the same in one's self. One can respond or react either positively or negatively to these perceptions.

These five subjects appear to be a case in point. All used their superior empathic ability to size up a situation and then reacted defensively rather than allowing it to become a phenomenon of identification, sharing, or participating. All demonstrated intense hostility, competitiveness, and antagonism toward members of their peer group and especially toward authority figures. The four subjects that KER worked with revealed in individual interviews a history of conflict with parents, members of peer group, school officials, and ecclesiastical superiors. To be sure, some were more subtle and sophisticated than others in their expression of negative and hostile feelings. But all utilized their superior empathic ability, not to enhance relationships, but defensively, i.e., to be "one-up" on everyone else. All seemed to be compensating for a felt weakness. One was hostile because of his inability to overcome his dependency-independency problem in relationship with his parents. Another had struggled with a physical limitation from early childhood. A third subject felt inferior athletically in early grades; he became hostile toward his peer group and sought to prove himself academically. The fourth subject identified with a father who could not relate easily with adults, but who could lavish his affection on young children. Three of the four possessed superior intellectual power which they used to manipulate and control relationships. As the program progressed, and neared the end, five subjects became less hostile and negative in their relationships. It is possible that with a greater security in relationships the need to be keenly alert to feelings of other persons was diminished and consequently was reflected in a decrease in empathy scores. However, the authors feel that a third hypothesis is needed to explain this phenomenon.

Finally, the authors conclude with the suggestion that the intensive group experience, coupled with an intensive student-patient relationship, activated and made conscious many latent feelings from which they could

[9]May, Rollo. *The Art of Counseling.* New York: Abingdon, 1939, p. 97.

not escape. Consequently, they were forced, by the supervision of their work, and group pressure, to examine their modes of relating to others and to authority figures. Due to the supervisor's expertness in interpersonal relations, the subjects found themselves bound up in a relationship from which they could not escape or manipulate. With the failure of their usual defenses the anxiety which accompanies greater self-awareness was intensified. The structure of the program did not allow for sufficient time for the subjects adequately to work through these conflicts.

We know that aggressiveness, hostility, and antagonism—certainly present very often in revolt against authority—decrease the possibilities of empathy, and frequently is a definite block to empathy.[10] This appears to be the most reasonable hypothesis to explain these decreases in empathy scores.

Studies of a more extensive nature, with a larger sample, and, perhaps, a more refined instrument,[11] should lead to greater understanding of the potential and actual contributions of the clinical experience in the development of empathic ability.

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[10]*Ibid.*, p. 90. also Olden, Christine. "On Adult Empathy with Children," *Psychoanal. Stud. Child.*, 1954, VIII, 111-126.

[11]We are of the opinion that there is a definite need for a more refined instrument for testing empathic ability. Perhaps Kerr's new test, *Primary Empathic Abilities* (Psychometric Affiliates, 1957), will provide greater sophistication in measuring the empathic response.

COMMUNICATIONS

Which Journal Will You Read?—A Statement on the Recent Survey of Journal Readers Conducted for the Editorial Board

In 1950, the *Journal's* sponsors—the Council for Clinical Training and the Institute of Pastoral Care—joined efforts to produce one journal in place of two, stating their purpose as *"sharing experiences and interpretations of pastoral work, interprofessional relationships, the theology of pastoral care, and clinical pastoral training."* You, the readers—chaplains, parish clergy and others, chaplain supervisors, seminary professors, students, other professions—are engaged in living encounter with these concerns or in preparation to meet them. Do you have unmet needs in this work which the *Journal* can serve? Last year, as we neared the close of a ten-year period, the Editorial Board started a review of the efforts of the *Journal* in relation to the purposes of its sponsors. The following is a brief summary of what we found out.

You like the *Journal.* That was what you said, most strongly. And we are both pleased and grateful. We want it to be of increasing value and help to an increasing number of readers. In order to make the *Journal* more helpful to more of your concerns, we are paying careful attention to your suggestions and criticisms. Your answers to our first mailing of the questionnaire have given us a valuable exploration of what the *Journal* can do for you. Repeated re-mailings of the questionnaire would be necessary before we could legitimately make statistical predictions from the sample, or statistical tests of relationships. What we do have in your responses are guides on what to emphasize in following up our study. Your concrete descriptions of how you see departments of the *Journal* and content for the *Journal* are more useful at this point than statistical conclusions. The things you have approved or praised we would continue to try to emphasize. The things you want added or changed may change the kind of *Journal* you will be reading in the future.

Counseling is the strongest concern in pastoral care for those of you (254, or about 17 per cent of those to whom the questionnaires were mailed) who replied to the survey. Next in index of importance, you are concerned with mental illness, the relationship of psychiatry and pastoral care, group work, pastoral care in the parish and with families, the role of the clergy, clinical pastoral training case data on the use of religious resources, standards for counseling work with adolescents, research in pastoral care, case data on specific problems, the professional team approach, physical illness, work with children, delinquency and crime. This is a formidable roster of work and of topics. The order of emphasis is thought provoking. Would the order hold good if we heard from more of you who did not reply to the first mailing of the questionnaire? What kind of material do you want in the *Journal* dealing with these topics?

For those of you who answered the survey, theory and research on pastoral care head the list as types of material, followed closely by book

reviews, clinical data from both parish and institution, and interdisciplinary discussion. Right here is where one of our problems begins. We would welcome clinical data on pastoral work in the parish. Case studies from either parish or institution must be contributed by those who are doing the pastoral care with a clinical background in these settings—and keeping case notes. And where is that study we are looking for, in which persons of two or three different disciplines present their team approach on their multi-disciplined view of the same case or working situation or clinical/pastoral problem?

The changes and improvements which you feel are needed in pastoral care and clinical pastoral education may provide another general guide to ways in which the *Journal* can be of service. We generalized your replies into the areas of need. Listed here are only the areas receiving the stronger responses.

1. *Development of Clinical Pastoral Education—20 per cent of responses.* Define and clarify objectives. Give attention to research, standards and standardization, motives and personality of those entering the field of clinical pastoral care.

2. *Preparation for Pastoral Care—12 per cent of responses.* Deepen and improve through increased preparation, application of new techniques. Increase number of pastors receiving clinical pastoral training and length of training they get. Provide continued education and development on the job.

3. *Clarification of Pastoral Care; Pastoral Role and Functioning— 11 per cent of responses.* Define and clarify pastoral role and pastoral care in comprehensive terms within the profession and in terms distinguishing its uniqueness among other helping professions.

4. *Integrate Clinical Pastoral Education with Theological Education and the Church—11 per cent of responses.*

5. *Relate Pastoral Care to Basic Fields of Knowledge—11 per cent of responses.* Theology, counseling concepts, psychiatry.

The topics and kinds of material you have asked for in the *Journal* will and do, we think, help to clarify the objectives of clinical pastoral education. Case data and interdisciplinary discussion should help to define and clarify pastoral care and to relate it to basic fields of knowledge. These materials may be of service in less direct preparation for pastoral care and the integration of clinical pastoral education with theological education and the general life of the Church.

Now the *Journal* has been able to do much of the above, over a span of several issues, with the exceptions noted where there is a lack of solid clinical material to be published. The suggestions, and criticisms, which might change the kind of *Journal* you get come from the divergence of interests between various groups of readers.

Most of you who replied (87 per cent) have had some clinical pastoral training. Most of you got acquainted with the *Journal* in some connection

with clinical pastoral training. Chaplain supervisors and chaplains make up 37 per cent of the respondents. Both these groups are involved in clinical (institutional) settings for their work, but only half of the chaplains are involved in any way in clinical pastoral education. Seminary professors, not involved in clinical settings but partially involved in clinical pastoral education, make up 5 per cent of the respondents. Parish clergy and other clergy, not involved in clinical settings and only a few involved in clinical pastoral education, make up 38 per cent. The remaining 11 per cent of respondents are students, not involved in either clinical setting or clinical pastoral education.

Replies to the open questions from these groups indicate some descriptive differences in interests and needs. These differences did not produce what might have been expected as the direction and weight of criticism. Parish clergy—and a few chaplains, chaplain supervisors, and seminary professors—want more clinical data applied to the parish. Obviously, the *Journal* has not been able to supply this. Yet parish clergy indicated on the whole much more satisfaction and suggestions than dissatisfaction with the *Journal* as it now is.

The critical differences in responses seem to be related partly to the reader's work involvement (chaplains, parish clergy, etc.) and partly to his preparation in what might be called dynamics of pastoral care or general clinical pastoral education. The parish clergyman reads theory and case illustration in terms of how it will help him in the parish—whether or not it is specifically detailed from the parish setting. The chaplain looks for principles and illustrations which help him with problems peculiar to ministering in the institution. The reader who has as yet only a beginning background in clinical pastoral education or equivalents may feel that the *Journal* is fairly technical. Yet some of you who are in this situation, who have been oriented to the field of clinical pastoral work but who are not able to engage in further formal training in it right now, feel the need for continued guidance and materials. On the other hand, chaplain supervisors engaged in the problems of training others and with the relationships of pastoral work and psychiatry at depth, want more materials directly related to their work and more exchange on their working problems.

Can these diverging needs be met in one publication such as the *Journal of Pastoral Care?* Ought we to try to meet them? These are the questions which the editors and the sponsors have been pondering. Balancing these diverging needs is the view that the *Journal* is establishing documentary material in the general field of clinical pastoral work, religion, and psychiatry. It is our understanding from your responses, as well as from follow-up conversations, that many of you feel that establishing the documentary material is basic to all the varied efforts in the field.

Thus the *Journal* would seem to have before it four possible patterns for development:

Pattern A: Scholarly and highly technical approach to theory and clinical substantiation, building a body of documentary material following the developments in the field and providing outlets for specialized and advanced work.

Pattern B: Interpretive and illustrative approach to developments and resources in the field, with some technical theoretical and research materials. Exposition of established areas of work and reporting of new developments.

Pattern C: Intraprofessional exchange between specialists in clinical pastoral education. Case material and working problems at the specialist's depth, with flexibility in presentation.

Pattern D: Combination of Patterns A, B, and C, including some continuing survey of developments and resources, introductory materials for those entering the field, scholarly and technical material, and intraprofessional discussion.

Which of the *Journals* would you read? You may want to write and tell us more than we have heard in this first mailing of the survey. Those of you who wish to contribute to the *Journal* may well be guided by the concerns briefly summarized here. There is plenty of challenge in your responses—a challenge we hope you will help us to meet.

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The Fall Conference of the Institute of Pastoral Care

The Institute of Pastoral Care held a Fall Conference of Chaplain Supervisors and those working toward accreditation as supervisors at the Congregational Christian Center in Framingham, Massachusetts, October 5-9, 1959. Thirty-five of the forty accredited supervisors were present, as well as twenty-four men in the "in-care" program.

Earlier in the year each of the supervisors had been asked to write a 1000-word paper on his "philosophy of clinical pastoral training." These papers had been printed, bound, and made available for discussion at the Conference.

At the first session of the Conference Chaplain Paul Swanson of Massachusetts General Hospital presented a critical evaluation of these papers. He discussed those concepts that were held in common by a majority of the supervisors and also pointed out that there are still many variations in the philosophy and practice of clinical pastoral training among Institute supervisors.

The Tuesday, Wednesday, and Thursday morning sessions were devoted to significant subjects related to clinical pastoral education. Dr. Arthur Becker, Supervisor at Children's Hospital in Columbus, Ohio, and faculty member of the School of Theology of Capitol University, presented a paper on the "Theology of Clinical Pastoral Education." Discussants were Dr. James H. Burns of the Massachusetts Council of Churches and Chaplain Daniel Sandstedt of Augustana Hospital in Chicago. Dr. James E. Flinchbaugh of United Theological Seminary, Supervisor at Miami Valley Hospital in Dayton, Ohio, spoke on the "Psychology of Clinical Educa-

tion." Dr. Otis A. Maxfield of the First Community Church in Columbus, Ohio, and Dr. Joseph F. Woodson, Supervisor at Massachusetts Mental Health Center in Boston, discussed this paper. "Education of Clinical Pastoral Education" was the subject presented by Dr. Charles W. Stewart, Supervisor at Colorado Psychopathic Hospital and faculty member of Iliff School of Theology. Discussants of Dr. Stewart's presentation were Dr. Rollin J. Fairbanks of the Episcopal Theological School in Cambridge and Chaplain William B. Spofford, Jr., Supervisor at Massachusetts General Hospital.

All these papers and discussions, as well as other materials from the Conference, will be published and made available at cost in the near future.

In other sessions of the Conference the question of internship and residency programs for chaplains was discussed, and a committee was appointed by the Board of Governors to evaluate this whole problem. The programs at Boston City Hospital and Worcester State Hospital were presented and discussed.

A particularly interesting and significant event occurred at the Tuesday evening meeting, when a gavel was presented to the Institute by Worcester State Hospital. This gavel was made from wood from the Chapel doors of the original hospital building, which was recently torn down. Since Worcester State Hospital, through Dr. Anton T. Boisen, played such a significant role in the beginning of clinical pastoral training, it seemed quite appropriate that the Institute of Pastoral Care should receive a token from this institution.

Certificates of accreditation as chaplain supervisor were presented to eight persons by Dr. John M. Billinsky, President of the Board of Governors. Following these presentations, Dr. Rollin J. Fairbanks gave a history of the Institute of Pastoral Care and the clinical pastoral training movement. Dr. John M. Billinsky, Dr. Paul E. Johnson, and Dr. Emil M. Hartl, all of whom have been involved in the clinical pastoral education movement since early in its history, commented informally on the subject.

The Conference offered some very practical stimulation to our thinking about clinical pastoral education, as well as a real opportunity for communication between the supervisors themselves and between the supervisors and members of the Board of Governors.

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Annual Conference of Supervisors of the Council for Clinical Training, 1959

The Annual Conference of Council Supervisors met in Christ Church Cathedral in St. Louis, Missouri, October 26-29, 1959. "Theology for Pastoral Work" was the topic of address by the Rev. Armen D. Jorjorian at the opening dinner on Monday evening. The dinner was attended by

eighty-five persons, including, in addition to Council supervisors, member seminary professors and guests. After the address by Mr. Jorjorian, Chaplain Supervisor at St. Luke's Hospital in Houston, Texas, further comments and discussion were contributed by the Rev. John Soleau of Virginia Theological Seminary and the Rev. John R. Thomas, Chaplain Supervisor at Austin State Hospital in Texas. The address and its discussion dealt with the tension and relationship between the ministry of proclamation and the ministry of healing.

Tuesday and Wednesday of the Conference were devoted to a series of workshops on first-quarter and advanced levels of training, with the total registration reaching one hundred in attendance during the week. The "Goals and Content of First-Quarter Training" were presented by Chaplain Supervisors Robert Robey of Lorton Reformatory, Washington, D. C., and Miles Renear of Metropolitan State Hospital, Norwalk, California. The "Goals and Content of Advanced Training" were presented by the Rev. Frederick C. Kuether, Director of Training at the American Foundation of Religion and Psychiatry in New York City, and the Rev. Thomas W. Klink, formerly Chaplain Supervisor at Topeka State Hospital and now Chaplain and Coordinator of Graduate Studies in Religion and Psychiatry at the Menninger Foundation. The issues and principles raised by these presentations were discussed in four workshop groups each day.

An individual research study carried out at South Carolina State Hospital was reported by the Rev. Obert Kempson, a section of the study having been presented in a previous issue of the *Journal*. Mr. Kempson's report on "Personal and Interpersonal Changes in Clinical Pastoral Training" was received with interest and a supervisors' Committee on Research was subsequently set up for one year of exploration and study.

Business sessions on Wednesday and Thursday heard the recommendations of committees and recommendations from the floor of the Conference. A special report was made by the Rev. Ernest E. Bruder on "Basic Issues Affecting Saint Elizabeths Hospital and Council for Clinical Training Relationships." The Special Study Committee also reported briefly.

Tuesday evening of the Conference was set aside for work of committees. A special joint meeting of Standards and Accreditation Committees was held Monday preceding the Conference for consideration of the certification of a year's training and of the training of supervisors. Also preceding the Conference, the Accreditation Committee started work on Friday, October 23, reviewing forty-one candidates, some for supervisory status and others for certification of the clinical year. Seven candidates were recommended for full status as supervisors; twelve were recommended for acting status; three were recommended for assistantships; and four were recommended for certificates as clinically trained chaplain.

Dr. Carroll A. Wise, President of the Board of Governors, addressed the Thursday morning session of the Conference, his address dealing with the Council as an expression of faith, with the organization of the Council,

and with issues affecting policy. Miss Emily Spickler, Executive Secretary, set forth briefly her recommendations for advancing the work of the Council during the coming year.

A special feature of the 1959 Conference was the luncheon meeting of member seminary professors with Regional Representatives and Committee Chairmen. A number of issues and procedures were discussed toward the improvement and development of providing clinical pastoral training for seminary students. It is hoped that future Conferences will be able to provide further for this type of meeting and that member seminary professors will find it possible to attend.

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BOOK REVIEWS AND NOTICES

EDITED BY THE REV. ROLLIN J. FAIRBANKS

Christ and Celebrity Gods. The Church in Mass Culture: Malcolm Boyd; Seabury Press, Greenwich, Conn., 1958. 145 pp. $3.50.

The great value of Mr. Boyd's book is that he learned his Hollywood from the inside before he acquired a clerical collar, and that he is not easily fooled by nonsense, even when it comes in the guise of religion. This book will be invaluable to any clergyman who keeps up with the movies, or gets in conversations with laymen who are devotees of the screen. Mr. Boyd demonstrates (especially through "The Ten Commandments") that immense shoddiness and fuzziness can go into the promotion of dubiously religious films (and that church people are easily "taken in" by the ballyhoo), and that conversely such a film as "Baby Doll" may have more integrity and Christian value than most of the Hollywood products that bear the religious label.

This reviewer finds the book to be particularly interesting because of its detailed analysis and evaluation of a fair sampling of "religious" and "secular" films. It is a first-rate presentation on a subject which has rarely been handled with such a competent combination of technical and Christian insight.

CHAD WALSH

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Family Relationships and Delinquent Behavior: F. Ivan Nye; John Wiley and Sons; New York, 1959. 168 pp. $4.95.

In a carefully composed study that is protected with adequate chi square significance and thorough correlation and association analysis, the director of the sociological research laboratory of the State College of Washington, Mr. F. Ivan Nye, has produced a worthwhile contribution to the understanding of delinquent behavior.

Unlike previous studies of delinquency which focused upon the populations of reformatories, juvenile court groups, and training schools, the author attempts to study delinquent behavior in the non-institutionalized general population. This rather difficult feat is accomplished by the utilization of a clever questionnaire method which seeks to comprehend deviant behavior within the sociological framework of the family unit. The project emphasizes current child attitudes and behavior patterns.

Written in a concise, easily read, semi-outlined form and using frequent charts and statistics as well as questionnaire examples, the author deals with such topics as *employed mothers, acceptance-rejection, discipline, punishment* and relates them to delinquent behavior in positive or negative and significant and insignificant terms. It is interesting to note that the author concludes from some of these relationships that knowledge of religion imputed to parents, religious rapport and frequent use of discussions of religious matter with parents all show significant associations with delinquent behavior. "That almost thirty per cent of high school children feel their fathers know little or nothing about religion is, however, somewhat surprising," writes Mr. Nye.

No vigorous attempt is made in the book to correlate adolescent deviant behavior with past experiences as a preschool and school-age child within the family unit. Furthermore, the author does not attempt to demonstrate the relationship between emotional illness and adolescent antisocial behavior, nor does he associate specific parental psychopathology such as flat affect, cyclothymic mood patterns, or blatant psychoneurosis with such behavior on the part of the teenagers.

However, the sharp focus upon the interrelationships within the family unit as having a direct or indirect bearing on juvenile delinquency is a step forward in the right direction. It would seem that future clinical investigation and research in this area would be stimulated by this excellent study.

NORMAN SCOTT BRANDES, M.D.

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Man on a Pendulum: Israel J. Gerber; The American Press, New York, 1955. 320 pp. $3.50.

This book is sub-titled *A Case History of an Invert.* Dr. Gerber, a rabbi, spent nineteen months counseling with John Edward Collins, and this is the story of Collins, written in biographical form, with some comments by the counselor. The contents deal almost entirely with the homosexual experiences of Mr. Collins, a few heterosexual experiences, his relationships with his mother and other assorted persons of less significance. There is very little discussion of counseling procedures or of the dynamics of homosexuality. After nineteen months of what we are led to believe was largely a matter of listening by the counselor, this relationship is terminated. Three years later the counselee had not reverted to homosexual experiences.

The book raises many questions. One concerns diagnosis. Was this man really an invert, or was he a neurotic with certain homosexual tendencies? This is an important question in assessing the nature and character of the cure. That the man had homosexual tendencies, there is no doubt, but there is also evidence of a rather frantic neurotic looking for a convenient outlet.

Another question is the value of the book in its present form. The motive of the author was to provide encouragement for other homosexuals to seek cure. But so much of the material is what one would expect to find between the covers of a lurid paper-back, and so little has to do with the process of cure that the question of its value could be legitimately raised. The book might as easily feed the fantasies of homosexually inclined persons. Personal testimonies have their place, but some questions might be raised about them, particularly in this form.

CARROLL A. WISE

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Clues to Suicide: Edwin S. Shneidman, Norman L. Farberow, et al.; McGraw-Hill, New York, 1957. 227 pp. $5.50.

This book, written by two psychologists in association with medical, social work, sociology and legal specialists, consists of a collection of papers which outline modern thought on the problem of suicide. Except for the first chapter each of the other 18 short chapters represents a summarization of modern thoughts and opinions about a different aspect of suicide. The

first chapter presents some interesting observations on suicide notes, and the remainder of this presentation consists of the authors' general observations about the necessary caution required in dealing with suicide patients. In Chapter 18, Dr. A. E. Bennett estimates the suicide deaths in this country to be 50,000 per year, which this reviewer considers to be quite conservative. A more realistic estimate would be closer to 150,000 deaths per year!

This small book constitutes a handbook on the complex problem of suicide, the first such publication known to this writer. It should be valuable to anyone who wishes to gain a comprehensive view of the problem without searching through the individual publications on the subject (nearly 500 in English and over 1200 in foreign languages in the medical literature alone). Since the act, or threat, of suicide is considered a symptomatic expression (rather than a specific disease entity), it requires considerable understanding of emotional disturbances in general. The book is quite readable and only occasionally might provide difficulty but this is because the content is at times complex, not because it was written in a mystifying manner. This volume should provide an excellent introduction to the subject for anyone who is interested and willing to accept the responsibility of the knowledge it can provide him.

VIGGO W. JENSEN, M.D.

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Experiment Perilous: Renee C. Fox; Free Press, Glencoe, Ill., 262 pp. $5.00.

Here is an unusual research project on the frontiers of medicine. A New England hospital, having undertaken with federal and fund grants to study the usefulness of certain newly synthesized steroids in the treatment of various partially understood clinical conditions (metabolic, endocrinological, cardiovascular, renal, and malignant), proceeded to make (under controlled laboratory conditions) an investigation of the stresses and strains of eleven young physicians and their fifteen patients. The author's research method was "participation observation" supplemented by focused interviews and tabulation of hospital charts. In its orientation the study is sociological rather than psychological, but in actual fact (in the nature of the case) it was a middle-ground fusion of the two. Three forms of uncertainty are described among the doctors (limited knowledge, limited skill, limited success), but the analysis is in terms of *shared* problems and *socially patterned* ways of coping, rather than subjective and "psychological" factors. Some of the day-to-day behavioral and discussional record is unusual and suggestive; for example, on the subject of "counterphobic, impious grim joking."

JOSEPH FLETCHER

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Dynamics of Group Action: D. M. Hall; The Interstate Publishers, Danville, Illinois, 1957. 240 pp. $3.95.

Although containing much useful information illustrated with helpful drawings and armed with resourceful appendices, Professor Hall's book suffers from a presentation that reaches so far afield for references and illustrations that the reader may fail to see the trees because of the forest.

The author's zeal and sincerity are evident, but the simple, elementary and even naive structure is more likely to impede rather than facilitate understanding. As a basic primer, the book undoubtedly has its place and will prove useful. Group dynamics, however, deserves a more ordered, definitive, and precise presentation.

ROLLIN J. FAIRBANKS

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Learning to Work in Groups: Matthew B. Miles; Bureau of Publications, Teachers College, Columbia University, New York, 1959. 285 pp. $5.00.

While directed primarily to those who are engaged in the great enterprise of education, from classroom teachers to those on boards of education, nevertheless Professor Miles' superb text has much to contribute to church groups and religious leaders. Although the frames of reference are largely those associated with schools, the description of group dynamics, leadership roles, and of the training process are set forth so clearly and meaningfully that in this reviewer's judgment *Learning to Work in Groups* is the best text presently available. It is recommended especially to those in theological education, particularly supervisors of clinical pastoral training.

Diagrams, report forms, and testing instruments are provided. A comprehensive bibliography is included. These, plus an excellent index, give the book a usefulness not always found in other texts.

ROLLIN J. FAIRBANKS

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Light Beyond Shadows: R. Frederick West; Macmillan, New York, 1959. 169 pp. $3.75.

The subtitle of this brief volume by a Disciples of Christ pastor in Raleigh, North Carolina, is "A Minister and Mental Health." A more accurate subtitle might be "A Minister and Mental Illness," since it is an account of the author's own experience of being mentally ill. The book begins with his commitment to a state mental hospital as a patient and then proceeds to describe the many adjustment problems he encountered, especially upon his return to his community.

The many stresses and strains that modern pastors are under today make this volume of special interest to any minister who knows what it is to try to meet the numerous demands placed on him as a leader of his community. The book is not designed as a "self-help" type; what it does do is to point up how many clergymen have gone through experiences similar to the author's, and the need for ministers, as well as society in general, to recognize mental illness as an illness comparable to other illnesses. The author has been amazed at how many other ministers have come to him since his hospitalization and confided that they too have had "a nervous breakdown," but have not dared to tell anyone about it.

This reviewer happens to be of the same denomination as the author so that the names and events of the denomination were familiar to him. For someone who is not familiar with them, the many references would probably be of little interest and the author could well have omitted many of these details. Very little reference was made to the work of the

chaplain in the state mental hospital. This was frankly a disappointment, but it may well be significant. The author does state that he was very grateful to the chaplain, but he offers little elaboration as to why he felt this way.

There are two striking things about this volume which should be noted. It must have taken considerable courage to come to the point of sharing this kind of an experience. The author is to be commended for this, because certainly there is a tremendous need for anything that will help reduce the stigma of being mentally ill. He is also aware of some of his limitations. He does not claim to be an authority on mental health or illness. He states this quite well: "To observe, study, and master . . . cases objectively is one thing; but to have been one yourself is quite another."

ARTHUR H. ROST

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Community Mental Health: Margaret C. L. Gildea, M.D.; Charles C. Thomas, Springfield, Illinois, 1959. 169 pp. $5.00.

The author describes in considerable detail the results of a twelve-year experiment in establishing and conducting a school-centered and group discussion program in St. Louis, Missouri. Though its basic concern was about the "problem child" in school, the program for aiding such children was largely carried out through informal group work with the mothers of these children. Significantly enough, where the mothers became interested and involved in the discussions, there was found to be a noticeable improvement in the behavior of the children.

It is obvious from the report as to how experimental such an approach really is. But for those concerned with mental health and especially for any means that can be developed to *prevent* future mental disturbance, this small volume offers many stimulating leads. It is the kind of study that would prove an invaluable source book of ideas for the development of a constructive program for many a moribund P.T.A. This is the very kind of report greatly needed and which throws considerable light on how to deal with the kind of problems which at present baffle many conscientious teachers and parents, even though the parents be parents of "problem children."

ERNEST E. BRUDER

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Dynamic Psychiatry in Simple Terms: Robert R. Mezer, M.D.; Springer Publishing Co. Inc., New York, 1956. 174 pp. $2.50.

The author sets forth a simple compilation of some of his ideas about dynamic psychiatry which he has taught medical students, nurses, and laymen interested in "social hygiene." Although he asserts that his objective is merely to make psychiatry understandable to the public, it is questionable whether even the interested layman would find the sketchy discussion very illuminating. It is obvious from several recent works that psychiatry in simple terms need not be oversimplified psychiatry. There are brief descriptions of several clinical disorders, some reproductions of standard diagnostic forms and diagrams which clarify nothing. The studious clergyman would rightly require special texts in order to learn

about dynamic psychiatry; he would not be satisfied with books that have only "simple terms" to recommend them.

AVERY D. WEISMAN, M.D.

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The Teaching and Learning of Psychotherapy: Rudolf Ekstein and Robert S. Wallerstein, M.D.; Basic Books, New York, 1958. 344 pp. $6.50.

This is the excellent fruit of ten years of careful scrutinizing of what goes on in the business of teaching and learning the intricate process called psychotherapy. The material presented came out of the experience gained through the authors' work in the Menninger School of Psychiatry, and it is an exceedingly well-written and thoroughly documented study of supervisory problems and concerns. To this reviewer's knowledge, there is nothing comparable to it in the literature. It is an invaluable source-book as well as an almost required textbook for any individual who would supervise the clinical training of others. In fact the book shares the experience gained in many of the same areas that have troubled the struggling chaplain-supervisor.

The authors shed much light and give a wealth of detail on the age-old question "training or therapy?" and they make it abundantly clear that, when the two are confused, both the therapist and student or patient suffers. The material demonstrates dramatically that unless this confusion is first clarified in the mind of the supervisor, the problem constantly gets in the way of the learning process.

The book also directs knowledge and experience to other such demanding concerns as: the dealing with confidential material in the supervisor-student relationship; the dangers inherent in the student's self-revelation of his weaknesses, as well as the learning gains when this can be achieved; the "confrontation" technique as a therapeutic adjunct to reveal a student's sensitivity, or lack of it, to the basic needs of the patient; and the need for the development of self-awareness on the part of the therapist if he seeks to do justice to the therapeutic needs of his patients. As the authors put it: "One can only work with the unconscious of another person when he has learned to work with his own, has relived his infantile neurosis, freed himself from its terrors, and has resolved his basic conflicts" (page 348). This latter prerequisite is unequivocally regarded as an essential for those doing therapy, but it is clearly recognized that very few present-day training centers make this an explicit requirement.

Structure in the supervisory process comes in for critical scrutiny, and it is made abundantly clear that, for the authors, the issue is not whether there be structure, but what kind of structure and how well it is understood and used to facilitate the learning goals. The use of recorded material, how the material is recorded, and the problems in using it to maximum advantage for patient, student, and supervisor will all throw considerable light on chaplain-supervisory relations. How does one go about making an adequate evaluation of a student's progress and work? To what extent can this be fruitfully done with the student and how? What are the dynamic factors as well as the administrative issues at the heart of these concerns? How can they all be utilized to the utmost as student and supervisor work together for the benefit of the patient?

All these and many other fascinating as well as complex questions are lucidly and helpfully spelled out with a wealth of clinical illustration.

It soon becomes evident in this presentation that the authors see supervision as a highly intricate but understandable *interpersonal* process. In fact, they make clear that neither technique nor learning can go on between supervisor and student unless supervision is seen from this perspective. This obviously makes more complex the understanding of the supervisory relationship, but it has its rich rewards in more meaningful relationships and the avoidance of the "guinea pig" attitude found all too often either in the therapist-client or supervisor-student relationships. It also provides that dimension so hard to define when we strive for what is often euphemistically called "the person-to-person" approach.

This volume is a veritable bonanza to the concerned supervisor. It will well repay the time needed for careful and critical study and restudy. Its contents, along with Harry Stack Sullivan's *The Psychiatric Interview,* and Frieda Fromm-Reichmann's *Principles of Intensive Psychotherapy,* will provide a library of invaluable information both to student and supervisor as they continue to struggle to understand the complex operations that go on between people meeting as persons.

ERNEST E. BRUDER

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Free Associations: Ernest Jones; Basic Books, New York, 1959. 264 pp. $5.00.

As the title implies, this volume presents in lucid and conversational style the recollections of one who was part of the intimate circle that surrounded Sigmund Freud and which furthered the present-day "psychoanalytical movement." However, if the reader expects to learn some of the hidden secrets or as yet undisclosed information about the "movement," he will be sadly disappointed.

The author makes clear that Freud spent many nights talking "'til three in the morning" with him; that "those were the days when I got to know Freud well." In another part of the book the author says fairly openly that Freud used to reveal to him his feelings about the "strife-torn and jealous giants" who pioneered in psychoanalysis. But the same quiet and almost studious reserve found in the massive three volumes Jones turned out on Sigmund Freud also marks his *Free Associations.*

This leaves those with serious interest in the development of psychoanalysis cut off from one of the real sources of information that could enlighten us as to the human and intimate characteristics that surely mark the leaders as well as the followers in our journey through life.

The volume is most readable and interesting for many reasons. Jones has always been a puzzle as to his negative and mechanistic views about religion. The memoirs present interesting clues that he too, like so many professional people, has found religion to be used negatively and manipulatively in his development. There is also a wealth of detail about the education of a medical student in London in the late Victorian era. There are many fascinating figures who flit all too cursorily through

the pages of the book as mentioned in the dust jacket, but Jones does little to help us get to know them.

Although this reviewer found the book fascinating, the element of disappointment far outweighs the interest its material evokes. True, Jones died before he completed the volume, but nowhere are there any indications that the mine of information which must have been his was ever going to see the light of day. And yet, of all the pioneers in the "psychoanalytical movement," he and Jung alone remained. Perhaps he left notes to be published posthumously and hence we may yet learn something of the intimate personal concerns of the great thinkers and explorers in the field as they struggled, sometimes bitterly, to make their way through the infinite complexities of the human psyche.

ERNEST E. BRUDER

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The Diary of Peter Parson: W. B. J. Martin; Abingdon Press, Nashville, Tennessee, 1957. 174 pp. $2.75.

This absorbing and challenging book is the late-night journal of an English Congregationalist clergyman. His thoughts, put down into brief essays, present the honest reflections of many clergymen. His complete and disarming honesty assumes that people are interested in his private thoughts, and this makes those thoughts interesting. Avoiding exaggerated idealism, home-spun humor, and sermonizing, Dr. Martin simply shares his speculations about many of those things which all ministers ponder: why we came into the ministry; advice given to young men in trouble; reflections in early life; problems in dealing with civic committees. He even questions the value of the Sunday School, and notes that "much of the preaching I have heard lately grossly overestimates the capacity of the ordinary man for sinning." *The Diary of Peter Parson* offers much material for thought and reflection.

J. FRANK SCHULMAN

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NEWS AND COMMENTS

The Rev. Ralph D. Bonacker has resigned his position as Director of the Episcopal Community Service in San Diego to become the Rector of the Church of St. John the Evangelist in San Francisco and General Presbyter in the Mission Presbytery in that city.

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Clergymen may now receive clinical pastoral training in the federal prison system under terms of an agreement reached by the U.S. Bureau of Prisons and the Department of Pastoral Services of the National Council of Churches. Prospective trainees who have received the endorsement of their respective denominations will be nominated by the Department of Pastoral Services, of which the Rev. Mark Shedron is Executive Director. Training will be done in residence at Lewisburg Federal Penitentiary in Pennsylvania. Internees may choose one to four quarters of work and will be paid by the Bureau of Prisons at the rate of $4040 a year. Openings will occur at regular intervals during the year.

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A pastoral counseling service, oriented to religion and established at the Pacific School of Religion, Berkeley, California, an interdenominational theological school, is made available to the community through the interest and support of the Hicks Foundation. The Rev. Robert C. Leslie, Ph.D., is Director.